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**IDENTIFICATION OF CORE MULTIDISCIPLINARY
COMPETENCIES IN AN INTEGRATED
PUBLIC HEALTH AND HUMAN SERVICE SYSTEM**

by

Brian Winslow Thomas Moffitt

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Education

University of San Diego

1998

Dissertation Committee

**Steven Gelb, Ph.D., Chair
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IDENTIFICATION OF CORE MULTIDISCIPLINARY COMPETENCIES IN AN INTEGRATED PUBLIC HEALTH AND HUMAN SERVICE SYSTEM

MOFFITT, BRIAN WINSLOW THOMAS, Ed.D. University of San Diego, 1998.

Director: Steven Gelb, Ph.D.

In response to economic, legislative and social forces, public health and human service systems are becoming more integrative, requiring direct service practitioners to acquire new competencies to successfully perform in these new settings. In a review of the literature, competencies pertaining to team effectiveness, interprofessional collaboration and cross-functional knowledge and skills all appear to be relevant considerations. Moreover, an examination of competencies must consider individual, team and organizational dimensions in a context of health and welfare reform. However, the current literature is fragmented, limited in scope and empirically inconclusive. A descriptive, qualitative study was therefore warranted.

The following research question was addressed: “What are the core multidisciplinary competencies perceived to be essential among direct service practitioners in an integrated public health and human service system?” I selected a pilot prevention and early intervention team who have innovative experiences adopting a multidisciplinary approach to integrating public health and human services. I conducted ethnographic interviews with consenting members of the team. A follow-up focus group was held, which served to clarify and validate interview data. Domain analyses of interview and focus group data was completed.

Data analysis yielded over 300 descriptors—key phrases or words that appeared to have some relation to learning (knowledge, skills and/or attitudes), whether at an

individual, team or organizational level. Descriptors were clustered into themes, which were then labeled. The themes were clustered into core competency areas. And core competency areas were organized into competency domains.

Four competency domains and seventeen related competency areas (in parentheses) emerged: 1) Pre-requisite Personal and Professional Competencies (interpersonal effectiveness, cultural competency, family and customer focused, multidisciplinary teams, and the county system); 2) Integrated Client Service Delivery (client advocacy and empowerment, information and referral, screening and early intervention, crisis intervention, case management, community resources, specific functions and populations); 3) Program Operations (planning and development, management and leadership, community collaboration, and administrative and technical); and 4) Organizational Competence (identifying and resolving challenges).

I concluded the dissertation with several responses to the research question. First, I framed the competency domains and areas into specific, behavioral competency statements. These statements can serve as tools for policy and organizational development, curriculum design and development, performance standards and appraisal, and rewards and recognition. Second I presented the implications of these competencies in light of the literature, noting areas of reinforcement and innovation. Third, I presented a multidisciplinary competency model, designed to promote individual, team and organizational learning to facilitate the integration of health and human services. I then discussed the limitations of this study and offered suggestions for future research and development.

DEDICATION

For Learners Who Inspire Learning

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One of the things a beginning doctoral student fantasizes about is the day they successfully defend their dissertation and perform that final, dramatic act—writing the acknowledgements. Now that the moment is here, it is difficult to summarize all that I feel and those I wish to thank!

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TABLE OF CONTENTS

CHAPTER ONE: STATEMENT OF THE ISSUE	1
Introduction	1
Economic, Legislative and Social Context.....	2
System Change	4
Purpose of the Study / Research Question	8
Summary	8
CHAPTER TWO: REVIEW OF THE LITERATURE	10
Introduction	10
Health and Welfare Reform.....	10
Adult Learning Theory	13
Continuing Education	16
Team Effectiveness	17
Interprofessional Collaboration.....	19
Cross Functional Knowledge and Skills.....	23
Summary	31
CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY	32
Introduction	32
Design of the Study	32
Site and Participant Selection.....	33
Protection of Human Subjects	36
Data Collection	37
Data Analysis	38
Validity and Reliability	38
Summary	39
CHAPTER FOUR: DATA ANALYSIS	40
Introduction	40
Competency Domain I: Pre-requisite Personal and Professional Competencies.....	43
Interpersonal Effectiveness.....	44
Cultural Competency.....	49
Family and Customer Focused	51
Multi-disciplinary Teams.....	53
The County (public) System	56
Competency Domain II: Integrated Client Service Delivery	60
Client Advocacy and Empowerment.....	60
Information and Referral	64
Screening and Early Intervention	66
Crisis Intervention.....	69
Case Management	72

Community Resources	74
Specific Disciplines and Populations.....	76
Competency Domain III: Program Operations.....	82
Planning and Development.....	82
Management and Leadership.....	84
Community Collaboration.....	86
Administrative and Technical.....	88
Competency Domain IV: Organizational Competence.....	90
Identifying and Resolving Challenges	90
Summary	96
CHAPTER FIVE: SUMMARY, IMPLICATIONS, AND	
RECOMMENDATIONS.....	98
Introduction	98
Multidisciplinary Competencies.....	99
Contribution to Research.....	104
Multidisciplinary Competency Model	111
Limitations	115
Suggestions for Future Research and Development.....	118
Conclusion	119
REFERENCES	121
APPENDIX	123

LIST OF TABLES

Table 1.0 – Competency Domains and Competency Areas	41
Table 2.0 – Interpersonal Effectiveness	45
Table 2.1 – Cultural Competency	49
Table 2.2 – Family and Customer Focused.....	52
Table 2.3 – Multidisciplinary Teams	54
Table 2.4 – The County (public) System	57
Table 3.0 – Client Advocacy and Empowerment.....	61
Table 3.1 – Information and Referral	65
Table 3.2 – Screening and Early Intervention.....	67
Table 3.3 – Crisis Intervention.....	70
Table 3.4 – Case Management	72
Table 3.5 – Community Resources	75
Table 3.6 – Specific Functions and Populations	77
Table 4.0 – Planning and Development.....	82
Table 4.1 – Management and Leadership.....	85
Table 4.2 – Community Collaboration	87
Table 4.3 – Administrative and Technical	88
Table 5.0 – Identifying and Resolving Challenges	91
Table 6.0 – Multidisciplinary Competency Research Matrix	105

LIST OF ILLUSTRATIONS

Figure 1 – San Diego County Health and Human Services Agency Service Delivery Regions	34
Figure 2 – A Multidisciplinary Competency Model for an Integrated Health and Human Service System.....	112

LIST OF APPENDICES

APPENDIX A - INFORMED CONSENT FORM.....	135
APPENDIX B - INTERVIEW GUIDE.....	136

CHAPTER ONE

STATEMENT OF THE ISSUE

Introduction

A variety of forces are impacting how government funded services are delivered. Publicly funded health and human services, in particular, may include the provision of alcohol and drug services, mental health services, physical health services, public health services, child protective services, financial assistance and employment programs, elder services, and other family and community support services. Changing demographics, increased customer demand, new technologies, and accelerating costs are prompting dramatic health and welfare reforms. These reforms include large-scale consolidation and integration efforts, requiring changes in how health and human service practitioners perform their jobs. Health and human service functions typically include alcohol & drug counseling, case management, eligibility and screening, and disciplines such as marriage, family and child counseling, nursing, psychology, medicine/psychiatry, social work, and a host of management and support staff in varying classifications. Academic institutions are attempting to modify and integrate curricula to prepare future practitioners through preservice education. There is a pressing need to provide current practitioners with continuing education programs to help them acquire the competencies to perform effectively in newly integrated settings.

However, the identification of these competencies is fragmented, vague and unsubstantiated.

Economic, Legislative and Social Context

Economic, legislative and social forces are impacting publicly funded health and human services. These forces reflect the current health and human service landscape, which illustrates the context within which this study was conducted.

In 1991, the United States spent \$750 billion on health care (12% of the gross national product); meanwhile, an estimated 34 million people have no health insurance at all (Gaebler and Osborne, 1992). Locally, approximately 410,000 San Diegans, or 22% of the population younger than 65, were uninsured (Brown, Valdez, Wyn, Yu and Cumberland, 1994). In 1992, 14.5% of the San Diego population were insured by Medi-Cal (California term for Medicaid). This is a higher percentage than in California (12.3%) or the United States (10%) (Brown, et al, 1994). These statistics indicate a higher dependence among local citizens for reliance on public resources.

Federal and state legislation has been enacted in an attempt to respond to these economic trends. In California, managed care legislation emphasized consolidation, which shifted federal funding for outpatient and inpatient behavioral and physical Medi-Cal funds to counties (*Plan for Mental Health System Redesign*, 1993). The legislation also prescribes the use of managed care technologies in an attempt to contain costs while simultaneously assuring quality of care. Another significant legislative change is

welfare reform. On August 22, 1996, President Clinton signed into law sweeping changes in the welfare system that created new programs and criteria for receiving public assistance (*Welfare to Work in San Diego County*, 1997). Fundamentally, the new federal law imposes greater personal responsibility on families, and envisions less governmental support.

Significant social changes are also impacting the delivery of health and human services in the public sector. There are profound demographic changes occurring across the country, and more dramatically in San Diego County. For example, the elderly population is growing at nearly twice the rate of the general population. Nationally, baby boomers (those born between 1946 and 1964) are turning 50 at the rate of one every 18 seconds (*Shelter From the Storm*, 1997). During the 20 years between 1990 and 2010, all age groups will increase 41%. Locally, the 60+ population in San Diego county will increase 69%, and the 75+ segment will grow an astounding 81% (*Shelter From the Storm*, 1997). The older adult population requires the most extensive and expensive services due to increasing disabilities and chronic conditions. In addition, San Diego ethnic projections indicate significant increase among African American, Asian/Pacific Islander, American Indian and Hispanic populations and a decrease among Anglo populations (*Future Scan*, 1995).

Another significant social force is the unique needs of the consumer of public services. Individuals and families who rely on publicly funded health and human

services fall into one of two general categories. One group of consumers are referred to as “Medi-Cal recipients”—those consumers who meet federal and state Medicaid eligibility requirements. The other group of consumers are referred to as “indigent”, those without any health insurance whatsoever who are entirely dependent on the public sector. Both groups have unique needs. Namely, they often have chronic illnesses (many have exhausted whatever private insurance they may have had), live in low income and poverty conditions, and are vulnerable to a host of destructive social conditions, such as domestic violence and substance abuse.

In recent years, the consumer and family empowerment movement has resulted in stronger advocacy and citizen/consumer involvement in policy-making and service planning and evaluation. Although public consumers’ expressions of need vary, there are common themes. For example, based on a review of volumes of consumer/family input, Roberts (October, 1997) identified six major themes that summarize what public consumers and families want: 1) Services that are available and responsive to their need; 2) a quick and efficient response; 3) personalized services; 4) to be treated with respect and professionalism; 5) one person/place to get help; 5) services that build on their strengths; and 6) services before a crisis.

System Change

In response to these economic, legislative and social forces, health and human service systems in the United States are undergoing dramatic changes. In their highly

influential book, *Reinventing Government*, Gaebler and Osborne (1992) provided a blueprint for the reconstruction of government funded programs, including health and human service systems. They argued that existing governmental systems couldn't meet these challenges; government needs to tap more into the entrepreneurial resources embedded in local communities and within the free market system. Here governments "steer" and communities and private entities "row". Such reconstruction leads to changes in work design and responsibilities (Howard, 1995; Kelly, 1995; Svehla and Crosier, 1994). Skill requirements in this new economy, according to Carnevale (1995), include "deep technical skills, as well as learning, communication, adaptability, personal management, group effectiveness and influencing skills" (p. 241). In addition, public employees are held more accountable by taxpayers and elected officials, and expected to learn and apply business principles to achieve specified outcomes.

For example, publicly funded health and human services in San Diego County are actively being reinvented. In 1995, the San Diego Board of Supervisors adopted a set of five strategies that formed the framework for the reconstruction of County services. The strategies call for: 1) Reforming federal and State resource allocation systems to allow greater local control and management of taxpayers' dollars; 2) encouraging and promoting the self-reliance of citizens through County policies and programs; 3) creating a smaller, more efficient/productive organization with fewer

services better delivered; 4) improving efficiency of services through consolidation; and 5) developing a performance-based human resources system (*Strategic Goals*, 1992).

Within this framework, the San Diego County Health and Human Services Agency (HHSA) was established to improve service delivery to San Diego's children, families, adults and older adults. The establishment of the HHSA involves the consolidation of the Department's of Social Services and Health Services, the Child, Youth and Family Commission, the Area Agency on Aging, Public Administrator and Public Guardian and the Veterans Services Office. The San Diego County Board of Supervisors approved an ordinance for the formal establishment of the Agency on November 7, 1997.

To guide this transformation, KPMG Peat Marwick, a consulting firm, was contracted to provide organization development services. The consultant team completed an assessment of the current situation by conducting a variety of surveys, document reviews and focus groups with all stakeholder groups, including staff, managers, providers, community members and consumers/families. Based on the assessment, the consultants and the HHSA "Project Synergy Team" developed a "To Be" service delivery model, based on business principles, that includes: 1) Improved customer service; 2) reduced internal administrative costs and increased service capacity; 3) a flatter, smaller and more accountable management structure and organization, 4) improved information management, 5) a seamless service network

integrating the Agency, communities and providers, and 6) an increased emphasis on community prevention and diversion to reduce the social and financial costs of families in crisis (*Proposed Agency Business Model Report, 1998*).

Transformation of the Agency to this new model required the establishment of a series of interdependent implementation projects encompassing a three-year, phased system change effort. Over twenty-five distinct yet interrelated project teams comprising staff, consumers/families, managers, providers and community members have been formed. Often times conflicting issues reflecting diverse stakeholder views are identified and discussed which requires modification of a given team's original charter. Issues that are not able to be resolved within a specific implementation team are brought forward to the Project Synergy Team for executive action.

One key recommendation included a significant investment in staff training. The primary area of training is called "cross functional knowledge and management" (*Proposed Agency Business Model, 1998*):

Agency staff will be expected to have a better understanding of the basket of services available from HHSA and its service delivery contractors. Many staff have developed and refined very specific skills required under the current program-oriented service delivery model. For the Agency to effectively break down these program barriers in service delivery, staff must have cross-

functional knowledge to better identify client needs and match them with Agency capabilities. (p. 43).

One example of where cross-functional knowledge will be necessary is in the information, assessment, and referral (IAR) function. Every HHSA program will be expected to provide IAR to any citizen entering its door. All HHSA direct service staff will ultimately perform the IAR function, representing a wide variety of disciplines and programs and are a primary target to receive cross-functional training. However, these competencies have not been defined.

The HHSA consolidation will involve the integration of approximately 6000 employees from management, support and direct service/clinical classifications, representing diverse organizational cultures, programs and disciplines. In addition to cross-functional training, a need exists to provide continuing education programs to facilitate team interaction and collaboration among staff who are accustomed to perform in a more autonomous manner. However, competencies needed to facilitate interprofessional collaboration appear to be vague and unsubstantiated.

Purpose of the Study and Research Question

In response to a variety of forces, publicly funded health and human services are becoming more integrative, requiring practitioners to acquire new competencies. However, as indicated earlier, such competencies have not been defined. A review of the literature (Chapter Two) validated this gap. A research study was therefore

warranted. The following research question was addressed: “What are the core multidisciplinary competencies perceived to be essential among direct service practitioners in an integrated public health and human service system?”

Summary

In response to economic, legislative and social forces, public health and human service systems are becoming more integrative, requiring direct service practitioners to acquire new competencies to successfully perform in these new settings. However, the identification of these competencies is vague and unsubstantiated. In Chapter Two, I conducted a review of the literature, which summarized prior attempts to address this issue, which validated the current lack of knowledge. In Chapter Three, I outlined the qualitative methodology used in this study. In Chapter Four, I described the core competencies that emerged from an analysis of the data. In Chapter Five, I discussed the implications of the findings and offered suggestions for future research.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

In reviewing the literature related to the identification of core multidisciplinary competencies among health and human service practitioners, it was first necessary to describe the current context in which this study was conducted. First, I summarized the key issues pertaining to health and welfare reform in this country. Second, given that this study focuses on adult learning, I discussed adult learning theory and continuing education. Third, given the emphasis placed on group interaction in today's economy, I briefly summarized what we know about team effectiveness. And, lastly, the majority of the literature search focused on the two overlapping areas that provide some insight into multidisciplinary competencies: interprofessional collaboration and cross-functional knowledge and skills.

Health and Welfare Reform

As I introduced in Chapter One, major reforms in health care and welfare are prompting large-scale changes in the way that health and human services are delivered. Managed care has emerged as a major issue in health care reform and has become a significant growth industry. Today more than seven in ten Americans find that their health care utilization is managed through health maintenance organizations or, more commonly, through contracts with preferred provider organizations or through the

utilization management of traditional insurance benefits (Sharfstein, 1990). States have already begun to design and implement managed care models to provide public health care, including mental health and related services (Center for Mental Health Services, 1996). There have been increasing concerns whether managed care really reduces costs, whether it adversely affects the quality of care, and whether it restricts access to care (Dorwart, 1990).

The debate among the mental health and psychiatric community has been particularly visible, prompted by the fact that persons with chronic and persistent mental illness have high service utilization patterns and outcomes are difficult to measure. For example, Patterson (1990) argued that

... rational mental health delivery is possible through an appropriate managed care system of independent providers. The right model for delivery of care incorporates principles that include rational assignment of clinical functions, epidemiological accountability, fiscal as well as clinical responsibility, open and direct patient access, incentives for preventive psychiatry, partnership between management and clinical providers, choice of services, outcome assessment, and interface between public and private providers. (p. 1092).

On the other hand, Borenstein (1990) argued that the patient review component of managed care plans adversely affects the therapeutic relationship:

Pressured to cut costs, reviewers are unlikely to be objective in their evaluation

of the need for treatment. Many are not qualified to review particular types of treatment. Avenues for appeal of reviewers' decisions are weak. The intensity and frequency of review are often disruptive both to the treatment and to the psychiatrist's practice. Some patients discontinue treatment after learning that their care is being reviewed because of fears about loss of confidentiality or other reasons. Informed consent procedures relating to release and protection of confidential information are inadequate. (p. 1095).

Both proponents and critics of managed care urge continued research, debate and policy development to guide future application of managed care in both health and mental health settings.

In addition, Blackwell and Schmidt (1992) drew needed attention to the educational implications of managed care, and predicted that "... managed care has the potential to provide the framework for an academic curriculum that encompasses both generic and specific areas of knowledge and skill." Furthermore, they suggested four major content areas: short term therapy skills, professional role development, ethical concerns, and cost-efficient care. However, they admit additional research is indicated.

Welfare reform represents another key issue that reflects the contemporary context of health and human services. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced what was Aid to Families with Dependent Children (AFDC) with Temporary Assistance to Needy Families (TANF).

Fundamentally, the new law reflects a significant paradigm shift from dependency to self-sufficiency. Most observers concur that achieving success in welfare reform requires a radical organizational culture change, especially in shifting employees' focus from eligibility assessments to job placements and retention (Hercik, 1998). Corbett (1995), for example, stresses the importance of developing a consistent message about vision throughout the welfare delivery system, and of reinforcing that vision with adequate resources for on-going training and development of staff as they re-orient themselves to their new mission.

The health and human service landscape at the time of this study is best exemplified by these enormous health and welfare reforms. The study I conducted specifically addressed multidisciplinary competencies needed to integrate health and human services, and did not focus on competencies needed to successfully implement managed care or welfare reform. However, I am hopeful that my findings may contribute to meaningful discussions regarding health and welfare policy issues, and subsequent discussions regarding organizational and educational implications.

Adult Learning Theory

Since this study focused on the continuing education of adults, I felt it was necessary to review adult learning theory and continuing education. Malcolm Knowles (1970) is considered the "father" of adult learning theory and is highly cited in the adult education literature. A central tenet of his work is an emphasis on the role of the adult

learner in his or her education. The assumption here is that by involving adult learners in the process, they will be more committed to acknowledging and developing their knowledge, skills and attitudes (KSA).

Davis and McCallon (1974) describe the concepts of learning KSA's.

Knowledge (or cognitive) learning includes the recognition, comparison, correlation, integration, perhaps creation, and storage of all kinds of data or information. Skill (or psychomotor) learning involves the notion of repetition, practice, or habit and includes procedures, operations, activities, methods and techniques involving repetition.

Attitude (or affective) learning includes the formation of values, emotional responses (feelings), and tendencies (interests, preferences, tastes, likes and dislikes). All three domains (knowledge, skills and attitudes) are interrelated and present in virtually any learning activity, yet the emphasis shifts, depending on the learner and the learned.

The holistic and learner oriented foundation established by Knowles paved the way for the development of *competency models* of adult or continuing education.

Competency, according to Davis and McCallon (1974), ". . . means sufficient knowledge and ability to meet and succeed in the necessities of living" (p. 52). Two general forms of competency models have emerged: expert based and learner based. Pottinger (1979) made the point that molecularization (breaking competencies down into specific behavioral objectives) trivializes learning. This reductionistic approach is expert based: it emphasizes models that have been analyzed, studied, and constructed

by experts rather than by "regular" employees. The expert model leads to the hierarchical arrangement of tasks, sub-tasks, and so on. The focus is on knowledge and skills, rather than the learner. Learner perception and input is clearly denied by this approach.

Consistent with Knowles' holistic and learner oriented foundation, the learner oriented competency model emphasizes the role of the learner in the construction of competencies (knowledge, skills and attitudes). The assumption here is that adults intrinsically seek to be competent and that learning is optimized when the learner is involved in all phases of adult education. In this view, learner perceptions of competencies are important and valid sources of data.

In recent years, adult learning has expanded beyond individual orientations. Prompted by a concern for efficiency and continuous quality improvement, team and organizational learning concepts have emerged that challenge traditional notions of training and development. For example, Senge (1990) wrote:

I believe the quality movement we have known it up to now [in the United States] is in fact the first wave in building learning organizations--organizations that continually expand their ability to shape their future. The roots of the quality movement lie in assumptions about people, organizations, and management that have one unifying theme: to make continual learning a way of organizational life, especially improving the performance of the organization as

a total system. This can be only achieved by breaking down the traditional command and control hierarchy where the top thinks and the local acts; to merge thinking and acting at all levels. (p. 2).

A key focus of quality improvement/organizational learning programs is to identify obstacles and barriers that impede the attainment of outcomes, and identify, learn and apply remedial strategies. Thus, learning is no longer an individual enterprise; rather, it is a multidimensional, systemic process.

Continuing Education

Continuing education is a planned intervention designed to improve individual, team and organizational performance (Abbatt and Mejia, 1988; Adelson, Watkins and Caplan, 1985; Boissoneau, 1980; Green, Grosswald, Suter and Walthall, 1984). The process of developing continuing education programs generically involves three key phases. Davis and McCallon (1974) described these phases as planning, conducting and evaluating. In the first phase, *planning*, assessment is the first step, followed by formulating specific learning objectives, selecting resources, designing learning activities, budgeting, making arrangements, rehearsing, and packing. In the second phase, *conducting*, setting up, setting the learning climate, agreeing on objectives, directing learning activities, and closing shop are completed. *Evaluating* comprises the third phase.

The first step in the construction or identification of competencies is the assessment phase. Needs assessment refers to any systematic process for collecting and analyzing information about the educational needs of individuals, teams and organizations and identifying discrepancies between current and desired competence (Adelson, Watkins, and Caplan, 1985). A variety of learner-oriented, competency-based needs assessments are available (see, for example, American Society for Training and Development, 1990). In addition, Davis and McMallon (1974) outlined several methods for identifying competencies and determining discrepancies between desired and observed performance behaviors: 1) consulting competent practitioners; 2) watching competent practitioners; 3) consulting relevant research; 4) conducting relevant research; 5) consulting supervisors; 6) reviewing job descriptions and performance standards; 7) conducting a task analysis; and 8) asking prospective participants (p. 53). Later I discuss the specific assessment methods I propose to utilize in this study; now I turn to the area of team effectiveness.

Team Effectiveness

Although there are hundreds of studies on team effectiveness, consistent key variables are evident. Several meta-analyses have been conducted recently to summarize what we know from all this research. For example, Johnson and Johnson (1992) conducted a meta-analysis on the effectiveness of teams for adults. In their examination of 120 studies, they found that overall working in teams resulted in higher

individual productivity than did working competitively or individualistically. And in their examination of 57 studies, they found that overall working in teams resulted in higher *team* productivity than did having team members work competitively or individualistically. In addition, they noted that working in teams was also found to promote more positive relationships and social support among members as well as greater psychological health, self-esteem, and social competencies.

Freeberg and Rock (1987) conducted a meta-analysis on 117 studies on team performance. They surmised that the most important influences on team productivity were prior experience doing the task, practice, how complex the task was, the way the task was structured, task load, amount of interaction among team members, degree of coordination among team members, and amount of cooperation among team members. Cooperation was a major influence on team productivity. Zhining Qin (1992; Qin, Johnson & Johnson, 1992) identified 63 studies examining the relative success of cooperative and competitive efforts on individual problem solving. She found that members of cooperative teams outperformed individuals who worked competitively.

Johnson and Johnson (1997) add that the productivity of teams, however, is not a simple function of team members' technical competencies and task abilities. To be productive, teams (like all groups) must ensure that members perceive strong positive interdependence, interact in ways that promote each other's success and well-being, be individually accountable, employ their small-team skills, and process how effectively

the team has been working. Johnson and Johnson (1997) summarized: "Nurturing teams includes training and retraining members as well as engaging in team building procedures to ensure that their effectiveness keeps improving" (p. 518).

Since most teams exist within organizational contexts, it is important to look at specific organizational variables that may support or hinder team effectiveness. Two key variables are the degree of interdependence structured among team members and social support. The greater the interdependence among organization members, the more positive the relations among divisions, departments, teams, and individuals in an organization (Brett & Rognes, 1986). The greater the social support in an organization, the higher performing the teams (Baldwin & Ford, 1988; Sundstrom, Perkins, George, Futrell & Hoffman, 1990). Organizational variables related to multidisciplinary effectiveness in integrated settings need to be acknowledged and identified since they may support or hinder individual, team or organizational learning.

In the following sections, I reviewed literature related to the identification of multidisciplinary competencies in health and human service contexts. Two interrelated themes were evident—interprofessional collaboration and cross functional knowledge and skills.

Interprofessional Collaboration

Collaboration is cited frequently in the literature (Aulbach, O'Shea, Hoffmans, Johnson, Baker and Hallisey, 1993; Browne, Smith, Ewalt and Walker, 1996; Bruner,

1991; Bryson and Crosby, 1992; Campbell, 1993; Chrislip and Larson, 1994; Collins, 1996; Cooley, 1991; Drinka, 1990; Ducanis and Golin, 1979; Forbes and Fitzimmons, 1993; Georgia Academy, 1992; Golin and Ducanis, 1981; Harris, 1996; Kinney, Strand, Hagerup and Bruner, 1994; Lappe and Dubois, 1994; and Rost, 1993) as a way to respond to large scale societal/organizational challenges for the betterment of children, families and communities. To achieve collaboration goals, considerable attention has been drawn to *interprofessional* education. Interprofessional practice and hence interprofessional education, as defined by the Commission on Interprofessional Education and Practice, means:

the communication, cooperation, and coordination that occurs between members of two or more disciplines when they are dealing with client concerns that extend beyond the usual area of expertise of any one profession. It is, in essence, a bridge-building enterprise designed to ensure that all significant aspects of complex client problems are accounted for when conditions are analyzed and treatments are determined and delivered. (Houle, Cyphert, and Boggs, 1987, p. 92).

In addition, interprofessional education implies on-going interaction among disciplines to achieve a common vision (Robertson & McCroskey, 1996).

There have been several attempts to identify the competencies needed for effective interprofessional collaboration. Smith and Hutchison (1992) conducted a

comprehensive study that involved an interdisciplinary literature search and review of 49 sources and a series of focused consultation groups involving three levels of human service professionals (N=33): direct service practitioners, mid-level program managers and policymakers. The professionals invited to participate in the focus groups were identified by their peers and supervisors as skillful collaborators. Both the literature on competencies and the practitioners participating in the focused group consultations cited the importance of valuing other professionals and professions, being well-versed in group process and communication skills, and establishing a common goal. The literature on interprofessional collaboration also emphasized the importance that each practitioner be well-versed in and be able to explain the perspectives of her/his profession, be able to surmount the barrier of jargon, either through knowledge of other professions' vocabularies or by using commonly agreed-upon terms, and be committed to collaboration through a recognition that the complexity of the problem(s) being addressed requires multiple professional perspectives and skills. The competencies identified by practitioners in focused consultations more frequently emphasized personality characteristics such as empathy, patience, openness to suggestions, and creativity, which were cited less frequently in the literature. The author's also critiqued the articles identified, noting that ". . . most discussions of collaboration identified to date lack quantitative/qualitative data supporting outcomes or claims" (p. appendix A).

Drawing on the growing body of writings on interprofessional education, Gardner et al (1997) completed a "working paper" consisting of a set of core principles. Based on these principles, they posited ". . . a set of values, knowledge and skills that professionals involved in interprofessional practice should acquire" (p. 1). They suggested that interprofessional education should provide professionals with the knowledge, skills, and values to be able to accomplish the following:

- 1) To take leadership in building a system designed to promote the well being of children, families and communities;
- 2) To work in teams, across traditional lines of programs, agencies, disciplines, professions, and communities;
- 3) To be accountable for results: the outcomes approach;
- 4) To be oriented to customers: clients, front-line workers, parents, and communities;
- 5) To understand policy as the context for practice;
- 6) To build on the power of multicultural diversity.

Similarly, the Missouri University Interprofessional Initiative Work Group (Summer, 1997) developed four general competencies: interpersonal communication, teamwork competencies, leadership competencies and community collaboration competencies.

Clearly, there are overlapping themes in the preceding works. However, it is not clear the extent these interprofessional competencies are based on rigorous research

methodologies. Furthermore, they are generic and did not address specific cross-functional competencies, which is the focus of the next section.

Cross Functional Knowledge and Skills

This section of the literature review focused on studies and articles that involved continuing education needs assessments to identify specific functional competencies in health and/or human service contexts. Although there are numerous studies in print, they are primarily limited to specific disciplines, including nursing, medicine, social work, health education and research and public health. This demonstrates the current mono-disciplinary focus in the literature. Later, I reviewed the few works that explicitly attempted to identify cross-functional competencies involving at least two disciplines.

The majority of assessment studies were limited to specific disciplines. For example, articles related to the assessment of continuing education for nurses focused on the general process of assessment (Courtemanche, 1995; Maloney & Kane, 1995; and Forker, 1996) or on a specific topic. For example, Fergusson and Diserens (1996) compared 1987 and 1995 survey results describing the continuing education needs of advanced practice nurses in pediatric oncology. Hekelman, Niles, Snyder and Stricklin (1995) conducted a study examining the perceived learning needs of visiting nurse association executives and staff nurses in Ohio in the area of gerontology. Similarly, Timms (1995) described a needs assessment effort that reinforced the use of a variety

of strategies to collect data to facilitate planning in relevant gerontological educational offerings. Carter and Axford (1993) conducted a study of computer learning needs and priorities of registered nurses practicing in hospitals. And, Schlosser, Jones and Whatley (1993) conducted a study that focused more on logistics and delivery rather than specific content.

The medical literature contains research that focused on assessing continuing education needs among general practitioners. Robinson, Spencer, and Neal (1996) assessed the perceived training needs of general practitioners (GP's) in order to identify the competencies needed by GP's for community-based clinical skills teaching. Pereles and Russell (1996) explored physician's responses to the needs for education in gerontology identified by a community needs survey. Norris, Coombs and Carline (1996) explored the hypothesis that a definable set of educational needs should be addressed for rural family physicians, both during their formal education and as part of continuing education while in practice. El-Guebaly, Lockyer, Drought, Parboosingh, Juschka, Weston, Campbell and Chang (1995) assessed priorities for family physician education. And, Hoffman, Tambor, Chase, Geller, Faden and Holtzman (1993) assessed primary care physicians' and psychiatrists' knowledge of genetics and genetic tests.

In addition to nursing and medicine, assessment studies have also been conducted that focus on social work, health education and research, and public health.

Browne, Smith, Ewalt and Walker (1996) surveyed social workers in a health care setting on the knowledge and skills they needed to help respond to new directions in the department. Marquez (1996) identified the perceived continuing professional education needs of certified clinical social workers in North Carolina. Noting the absence of well-defined competencies for the health educator (training and development professional), Pazak (1989) assessed the training needs of health care educators and their interest in obtaining continuing education. Cooper (1983), recognizing that current health education faculty in community college settings will be required to design and implement interdisciplinary education for future practitioners, assessed faculty development needs in order to bring about necessary curriculum changes. Field, Tranquada, and Feasley (1995) argued that health services research, as a field of study, has an important contribution to make in documenting and evaluating the effects of health care restructuring and made specific training recommendations. And, Berman, Perkocha, and Novotny (1995) conducted a continuing education preference survey of public health graduates among the alumni of the University of California, Berkeley, School of Public Health.

These studies provided insight into the continuing education needs of persons in specific disciplines, including nursing, medicine, social work, health education and research and public health. They did not explicitly address cross-functional

competencies needed across disciplines in an integrated health and human service system. What follows is a review of the few studies in this area.

Henry, Sullivan and Campbell (1993) assessed deficits in AIDS/HIV knowledge among physicians and nurses at a Minnesota public teaching hospital. Their results revealed a broad deficit in knowledge about the natural history and treatment of HIV infection and demonstrated the need for a clinically relevant core HIV/AIDS knowledge curriculum and for strategies to better educate health care providers to improve care given to HIV-infected patients. Knowledge of HIV/AIDS may in fact be a multidisciplinary competency. However, this study was limited to the disciplines of nursing and medicine.

Spencer, Shadick and Kasik-Miller (1996), interested in the multidisciplinary care of elderly patients with Type II Diabetes, conducted a survey to assess the continuing education needs of health care professionals providing diabetes self-care management and nutrition therapy to patients in rural northern Wisconsin. Respondents ranked themselves lowest in knowledge and experience in the following areas: 1) application of revised guidelines for medical nutrition therapy, 2) considering patients, differing cultural needs, and 3) team management of diabetes. They were most comfortable with the technical aspects of care, e.g., insulin administration and blood glucose monitoring. The competency of Type II Diabetes seems to be highly

specialized and not a multidisciplinary competency relevant for integrated health and human service practice; yet, this needs to be ruled out empirically.

Gravitz (1980) assessed the basic competencies required for entry-level management in the human services and to develop a collaborative interdisciplinary graduate education model for entry-level management in the field. Competencies included needs assessment, planning, prioritizing, method (delivery system) accountability and assessment, community relations, inter-agency relations, agency function, services and programs, personnel management, supervision, and communication. The competencies associated with management are not directly related to multidisciplinary practice.

Two interdisciplinary studies addressed evaluation of continuing education. Dietz (1993), for example, explored how human service professionals use a short-term continuing professional education (CPE). Workshops were targeted to interdisciplinary human service providers, including social workers, counselors and nurses, who work with pregnant and parenting teens and youth at risk for early pregnancy and/or substance abuse. Findings indicated that use of CPE occurs in multiple and diverse ways and varies across four dimensions: 1) component of workshop used, 2) with whom information is used, 3) how participants use information, and 4) conditions related to using information. In addition, Silverstone (1991) evaluated the effectiveness of four interdisciplinary training conferences on empirically based, state-of-the-art

treatments for adult depression. Although these studies evaluated interdisciplinary training programs, they were limited in scope.

Taylor, Bradley, and Warren (1996) developed skill standards (competencies) for direct service workers in the human services, focusing on ". . . essential activities that all direct service jobs have in common across the complex landscape of human service work settings and populations" (p. 3). Project staff assembled a broad consortium of partners representing employers, labor, professional associations and consumer and family organizations. This team guided the development, validation, and implementation of the standards. Competencies included participant empowerment, communication, assessment, community and service networking, facilitation of services, community living skills and support, education, training and self-development, advocacy, vocational, educational and career support, crisis intervention, organizational participation and documentation. This study did not address health care competencies, although it did produce a comprehensive array of human service provider standards.

Noting the need to produce a core, integrated curriculum needed to produce future generalist health care practitioners, Rodriguez (1997) analyzed knowledge/skills job specifications that closely correlated with the criteria used by the National Health Care Skill Standards Project. A total of 116 separate courses offered by seven health programs in the Maricopa County Community College District in Arizona were

evaluated using computer analysis and expert review. Fourteen core competency categories emerged, including academic foundation, communication, health care systems, employability skills, legal and ethical responsibilities, laboratory testing, safety practices, perform/assist physician, health maintenance, physician's office, intrateam communication, patient monitoring, patient mobilization, and pharmacology. Clearly, this study provided direction for the development of an integrated, preservice health practitioner curriculum; however, it did not address the continuing education or human service dimensions.

Locally, Lefkarites, McGann and Yeaker (1995) conducted an assessment to quantify the need for, and the capacity to provide public health continuing education in San Diego county, California. The study was conducted with the objective of developing and offering courses to the local County Health Department by the San Diego State University Graduate School of Public Health (SDSU-GSPH). Survey instruments were developed to separately assess the continuing education needs of public health practitioners and the capacity of SDSU-GSPH faculty to provide courses in San Diego County. The faculty survey was distributed to all full-time SDSU-GSPH faculty. Practitioner surveys were distributed to a systematic sample of divisions in the County of San Diego Department of Health Services (including alcohol and drug services, mental health services, and public/physical health services). Prioritized topics in greatest demand by public health managers were acute disease outbreak investigation

methods, epidemiology, government regulations and public health, and law and public health. Prioritized topics in greatest demand by mental health practitioners were interventions for health behavior, community mental health, nutritional assessment, and maternal and child health. Reported faculty interest and capacity to teach continuing education courses appeared to be limited. The analysis confirmed a need to improve and increase SDSU-GSPH public health continuing education offerings. Further, their results suggested that external instructional resources would be needed to meet this educational demand. However, their study did not address continuing education needs across the disciplines in the department, nor were human service dimensions investigated.

The bulk of cross functional competency needs assessment studies focused on specific disciplines, such as nursing, medicine, social work, health education and research, and public health. A few studies assessed competencies across disciplines. These studies are suggestive yet limited in scope and inconclusive in terms of their multidisciplinary application, notably the direct service skill standards and the generalist health care skill standards. Additional research is indicated to identify cross-functional knowledge and skills needed for integrated health and human service practice.

Summary

In response to a variety of forces, publicly funded health and human service systems are becoming more integrative, requiring practitioners to acquire new competencies. Continuing education is a tool for acquiring competencies to improve individual, team and organizational performance, with assessment being the first step. In a review of the literature, competencies pertaining to team effectiveness, interprofessional collaboration and cross-functional knowledge and skills all appear to be relevant considerations. Moreover, an examination of competencies across these dimensions needs to concurrently identify organizational variables that support or constrain learning. However, the current literature is fragmented, limited in scope and empirically inconclusive. A descriptive study that addresses this issue is therefore warranted.

CHAPTER THREE

RESEACH DESIGN AND METHODOLOGY

Introduction

In this chapter, I described the design of the study, site and participant selection, protection of human subjects, data collection, data analysis, validity and reliability.

Design of the Study

Meriam (1988) posited: "How the problem is defined and the questions it raises determine the study's design" (p. 29). Qualitative research is descriptive, and can help explain causal links that cannot be ascertained by experimental strategies (Merriam, 1988). Lincoln and Denzin (1994) added that "Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape reality . . . They seek answers to questions that stress how social experience is created and given meaning" (pp. 3-4). Since prior research related to the research question posed in this study is fragmented and inconclusive, a qualitative approach was considered by the researcher as an appropriate beginning.

To gather the data needed to respond to the research question—"What are the core multidisciplinary competencies perceived to be essential among direct service practitioners in an integrated health and human service system?"—I conducted in-depth

ethnographic interviews. Van Manen (1990) explained: "Ethnography studies the culturally shared, common-sense perceptions of everyday experiences . . . the ethnographer wants to understand what one has to know, as a member of a particular group, to behave competently as a member of that group" (pp. 177-178).

Ethnographers interview key informants, those who are enculturated and currently involved in the cultural context to be studied. The use of the key informant method for needs assessments presupposes the existence of a select group of people who hold or have access to most, if not all, of the information needed to evaluate a target population (Soriano, 1995). And, according to Soriano, "An important advantage of the key informant method lies in the limited number of participants needed, because key informants are presumed to have a broad knowledge of needs within the targeted area" (p. 22).

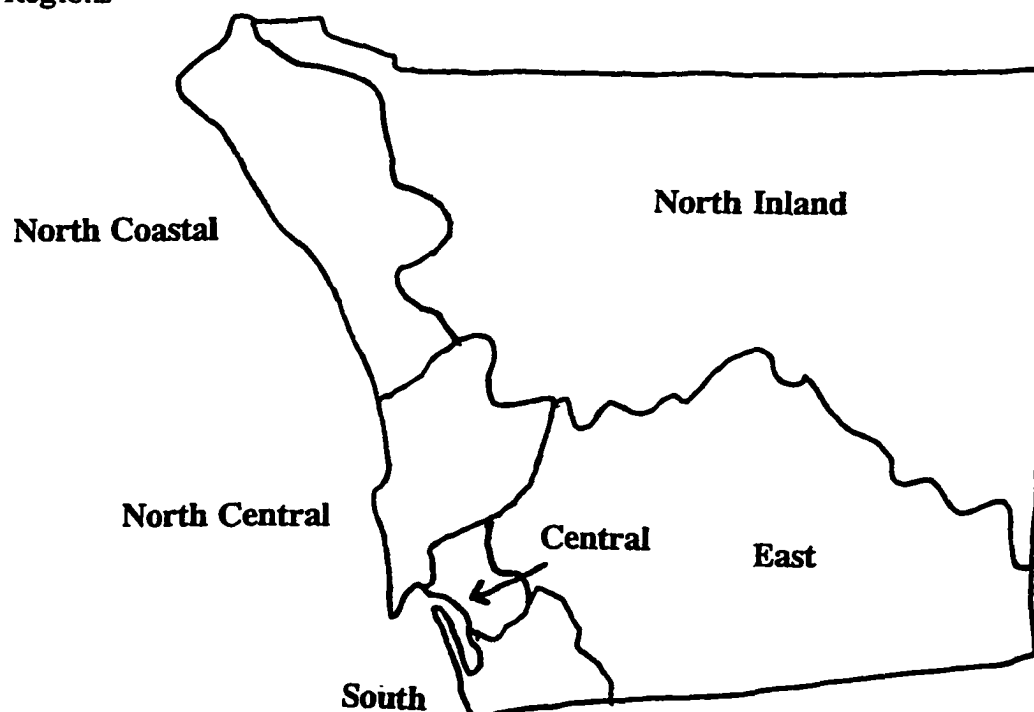
Site and Participant Selection

As directed by the San Diego County Board of Supervisors, the former County Department of Health Services (now subsumed into the Health and Human Services Agency), underwent a management audit by Public Administration Service (PAS) in 1995, a management/consultant firm specializing in government institutions (*Management Review of the Department of Health Services*, 1995). In short, the PAS study proposed the creation of a public health care delivery system that supports individuals and families in their efforts to become self sufficient, which will result in

healthier communities. An integrated, multi-service ("one stop shopping"), community-oriented, prevention focused and outcome based delivery system would support this goal.

This direction prompted the creation of a pilot program to test these outcomes. Health and human service delivery areas in San Diego County have been divided into six regions. The north inland region was selected to pilot a multi-service delivery model headquartered at the Escondido Public Health Center (Figure 1). The pilot began in January, 1997 and is called the "Prevention, Early Intervention Team (PEIT)" (*North Inland Pilot Overview, 1997*).

Figure 1. San Diego County Health and Human Services Agency Service Delivery Regions



The PEIT is comprised of a multidisciplinary team of seven, including a mental health clinician (clinical psychologist), alcohol/drug clinician, public health nurse clinician, community worker, front line worker and support staff, under the direction of a regional manager, also a public health nurse. Members of the team frequently work collaboratively with professionals from other disciplines (e.g., medicine, case management, etc.). The PEIT provides screening, assessment, and referral and short term case management. The pilot is testing if the program helps with earlier identification and prevention of illness or need, facilitation of access to needed services, and reduction in duplication of effort. Although the PEIT originated as a health services pilot, team members frequently screen, assess, refer and manage a variety of cases--"whoever walks in with whatever problem"--that involve other Health and Human Service Agency entities, notably the former Department of Social Services and Area Agency on Aging. For this reason, the PEIT is being closely examined as a potential service delivery model for the newly formed Health and Human Services Agency. Moreover, San Diego's newly formed Health and Human Services Agency is being closely watched by other county and state health and human service entities as a potential national model. Thus, the PEIT is an important and viable study group.

The PEIT were viewed by the researcher as key informants. They possessed valuable experience pertaining to teamwork, interprofessional collaboration and cross-functional knowledge and skills within a larger organizational context. Consistent with

the learner oriented competency model, I involved members of the PEIT in the construction of core multidisciplinary competencies that they have found to be essential in their integrated health and human service pilot program.

Protection of Human Subjects

Members of the PEIT were invited to voluntarily participate in the study. The parameters of participation were clearly explained to each participant. Participants were free to withdraw from the study at any time. This researcher is employed in the same system as the PEIT, holds the title of Health Services Training & Development Manager, and does not have a supervisory relationship with the PEIT. It was anticipated that participation in the study would not affect the informant's job status in any way. In fact, participants helped to shape future continuing education programs, which they will be able to benefit from. The PEIT were identified in this study as the data source, which may inadvertently lead to the identification of individual study participants. All quotes and descriptions were carefully reviewed to assure names, job titles or disciplines were omitted. All audiotaped and transcribed data were kept in a locked file in the researcher's home. PEIT members had an opportunity to review their respective interview data to review and may make any changes they deemed necessary. All audiotaped and transcribed data were destroyed upon completion of the study. Study volunteers were asked to review and sign an informed consent form (Appendix A).

Data Collection

Data was collected using exploratory interviews and a follow-up focus group. I interviewed six members of the PEIT (one member chose not to participate in an interview). I conducted one, 35-60 minute semi-structured, open-ended interview with six participants. I asked descriptive questions (Spradley, 1979) to develop rapport and elicit information. I began by asking what Spradley (1979) has termed "grand tour" questions (e.g., "Describe a typical day in your job as a member of the PEIT?"), leading to example questions ("Describe the knowledge, skills and attitudes you needed to do your job?"), to experience questions ("Can you describe an example of a situation where you didn't feel you had enough knowledge to help the client?"), and native language questions (e.g., "What word best captures the kind of skill you just described?"). In addition, I asked questions to identify learning needs across individual, team and organizational dimensions along with factors that are perceived to support or hinder the acquisition and application of learning. Following these guidelines, I developed an interview guide (Appendix B). Each interview was recorded and transcribed verbatim. Interviews were held at various locations (North Inland and Central San Diego), dates (February 27 - March 5, 1998) and times (during normal PEIT work hours) at the convenience of each participant.

After the interviews were completed, I conducted a two-hour focus group with all seven members of the PEIT at their Escondido office (North Inland Region) on

March 27, 1998. Given the team emphasis of the PEIT, I felt it was justified to explore perceptions in a group setting. In the focus group, I presented the domains (themes) based on data solicited in the individual interviews. I facilitated a process whereby each domain (major theme and related sub-topics) was critically examined by the team. The researcher presented each domain on separate flipcharts. Consensual and problematic domains, along with corrections and modifications, were made directly on each flipchart and served as the transcription for the focus group. For this reason, the focus group was not tape-recorded.

Data Analysis

Domain analyses of interview and focus group data was completed. Spradley (1979) explains: "Domain analysis involves the search for larger units of cultural knowledge called domains" (p. 94). Interview transcripts were carefully reviewed and coded for emerging, recurring or common themes. Critique and refinement of domains occurred in the follow-up focus group. Here, research participants were actively involved in the analysis of data, which Guba and Lincoln (1989) term "constructivistic" research: ". . . constructions held by people are born out of their experiences with and interaction with contexts" (p. 60).

Validity and Reliability

Accuracy of qualitative data was attained in two ways. First, study participants were invited to review their respective interview transcript. Five members chose to

review their transcript; one member submitted written changes. Second, the focus group provided the PEIT with an opportunity to critique, modify and refine domains (core competencies). According to Patton (1990), "Focus group interviews . . . provide some quality controls on data collection in that participants tend to provide checks and balances on each other which weed out false or extreme views" (p. 135).

Summary

In this chapter, I outlined the methodology used in this dissertation. Specifically, I described the design of the study, site and participant selection, protection of human subjects, data collection and analysis, validity and reliability. In the next chapter, I provided an analysis of the data collected from the interviews and focus group.

CHAPTER FOUR

DATA ANALYSIS

Introduction

The purpose of this chapter is to present an analysis of data collected for this qualitative, descriptive study. The goal of this research project is to answer the following question: “What are the core multidisciplinary competencies perceived to be essential among direct service practitioners in an integrated public health and human service system?”

Four competency domains emerged from the data: 1) Pre-requisite Personal and Professional Competencies; 2) Integrated Client Service Delivery; 3) Program Operations; and 4) Organizational Competence. I began the analysis by coding the data from the interviews, capturing key words or phrases that appeared to have some relation to learning (knowledge, skills and/or attitudes), whether at an individual, team and/or organizational level. Over 300 descriptors were compiled from the data. I clustered these descriptors into themes (abilities, knowledge and/or skills), which were labeled. The themes were then clustered into core competency areas. Finally, I organized competency areas into competency domains. This arrangement of interview data was then presented to the focus group for review, validation, and refinement. Competency domains and related competency areas are listed in Table 1.0.

Table 1.0: Competency Domains and Competency Areas

Competency Domain	Related Competency Areas
Pre-requisite Personal and Professional Competencies	<ul style="list-style-type: none"> • Interpersonal Effectiveness • Cultural Competency • Family and Customer Focused • Multidisciplinary Teams • The County (public) System
Integrated Client Service Delivery	<ul style="list-style-type: none"> • Client Advocacy and Empowerment • Information and Referral • Screening and Early Intervention • Crisis Intervention • Case Management • Community Resources • Specific Functions and Populations
Program Operations	<ul style="list-style-type: none"> • Planning and Development • Management and Leadership • Community Collaboration • Administrative and Technical
Organizational Competence	<ul style="list-style-type: none"> • Identifying & Resolving Challenges

The organization of this chapter reflects the following structure. First, I introduce the competency domain and related core competency areas. I then present a competency table for each core competency area. Within each table, I include specific themes (framed as abilities, knowledge and/or skills) and related descriptors. In addition, I weave into the text a series of quotes from participants. This gives context to the competency area in question and, coupled with the themes and descriptors, serves as data to support the analysis. I emphasize that many quotes relate to more than one competency area. In fact, some quotations relate to more than one competency domain. This is so because people do not speak in discrete categories or contexts; as human speech is more organic and recursive in nature. Nevertheless, quotations were selected to support specific competency domains or areas because of a predominant--not exclusive--relationship. In other words, readers are advised to read in linear terms, and to think in holistic terms.

The participants of this project are members of the County of San Diego, Health and Human Services Agency, Prevention and Early Intervention (PEIT) pilot project. The PEIT provides services to clients in the North Inland Region (Escondido area). The PEIT is comprised of a multidisciplinary team of seven, including a mental health clinician (clinical psychologist), alcohol/drug clinician, public health nurse clinician, community worker, front line worker and support staff, under the direction of a regional manager, also a public health nurse. Members of the team frequently work

collaboratively with other professionals representing diverse functions and disciplines. The PEIT provides screening, assessment, and referral and short-term case management. Team members are all female; estimated age ranges are 35 to 65. Five members are Caucasian; two members are Hispanic and bilingual Spanish. Six members agreed to participate in the interviews and signed consent forms. All seven members agreed to participate in the focus group.

Competency Domain I: Pre-requisite Personal and Professional Competencies

This domain comprises personal and professional competencies. These competencies constitute the fundamental knowledge, skills and/or attitudes needed before one engages in multidisciplinary practice. For this reason, the members recommended during the focus group that the word “pre-requisite” be added to the domain title.

The following competency areas are categorized in this domain:

- 1) Interpersonal Effectiveness;
- 2) Cultural Competency;
- 3) Family and Customer Focused;
- 4) Multidisciplinary Teams;
- 5) The County (public) System.

Interpersonal Effectiveness

Six major themes emerged from the data that relate to interpersonal effectiveness: supportive, positive, flexible, pragmatic, ethical and open. Related themes and descriptors are illustrated in Table 2.0.

Descriptors related to supportive included “availability”, “hear people’s distress”, “help people relax”, “create a safe and comfortable place”, “ease feeling of rejection”, “able to understand” and “sympathetic”. Interestingly, the data evidenced that the inter-relatedness of interpersonal attributes is particularly high in this competency area.

For example, the ability to be flexible was strongly related to communication and fairness by one member: “I think in terms of attitudes I needed to be extremely flexible. Communicate, communicate, communicate, upwards, downwards and sideways and I needed to be fair”. Another respondent’s flexibility seemed boundless: “I’ll do anything. I’ll set other duties aside, that’s me”. Flexibility was also linked to the ability to be supportive, including being sympathetic and a good listener: “... you have to be a very tolerant person, flexible, definitely flexible and a very good listener and you have to listen to all their problems and be sympathetic.” And, another member correlated rigidity and ethics: “... we can’t have too much rigidity, except we have to be rigidly ethical and rigidly promoting the well being of the client.”

Table 2.0: Interpersonal Effectiveness

Themes	Descriptors
Ability to be supportive	Availability; hear people's distress; help people relax; create a safe and comfortable place; ease feeling of rejection; able to understand; sympathetic
Ability to be positive	Upbeat; feeling of hope for people; champion; celebrate; sense of humor
Ability to be flexible	Willingness to do anything; interact with everybody; make adjustments; can't be too rigid
Ability to be pragmatic	OK not to know; know what the boundaries are; [staff] know their limits
Ability to be ethical	Rigidly ethical; confidentiality; fair
Ability to be open	Nonjudgmental; tolerant

In addition to flexibility, being open--non-judgmental--was another important theme. Specifically, the need to provide a safe and comfortable environment for discussing difficult issues was illustrated by one member:

... we had a handful of people that came back to us, maybe two or three months later, and said they either had a new problem and felt that we were a safe and comfortable place to come to or maybe they weren't as completely open as they had alluded to being when they participated in the first interview, and this would be particularly around sensitive areas around substance abuse or alcohol and maybe they didn't reveal to us a current problem or a family member's problem but they at least had the impression that we were there to help and they felt comfortable coming back to us later and asking for help.

The notion of being comfortable was reinforced when one respondent likened openness to respect and listening: "I don't care what the classification of the person is, it's somebody who is comfortable with people, is respectful and non-judgmental and listens well". Again, respect was noted in this member's response, along with providing undivided attention:

It is maybe not so much a clinical style but as I'm here as the helping person. I'm going to give you my undivided attention, I'm going to treat you with respect and I'm not going to judge you or your life.... There are people who are hungry for that kind of attention and support. So I don't care if you're trained as a clinical social worker, a public health nurse, a psychologist or the intermediate clerk typist, you can all do it.

The ability to be positive was another important theme. One member discussed this area in terms of maintaining a sense of humor, celebrating and recognizing:

... you need to maintain a sense of humor and celebrate and recognize these hard workers. I am one who believes in having the birthday parties and going to lunch and inviting people to your house for a special thing or the little thank-you note and remembering their children's names and what they are doing. Because we're all individuals with lives outside of 8 to 5, I think it's really critical ... to know ... staff as people and not just workers.

Another respondent linked the theme of positive with the theme of supportive to help ease feelings of rejection:

... I think this job always needs a positive attitude. These people come in and they need help. They're not looking for someone who is nasty ... they have been turned away, or turned down or the door slammed in their face so many times and not gotten what they really truly need because they don't know how to work the system or access the system. They are at their wits' end. They need someone positive, somebody that's going to do as much as they possibly can instead of pushing them to the next person ... willing to listen and ease that feeling of rejection.

Positive was also described in terms of maintaining an open mind with the team: “A positive, upbeat attitude, keeping an open mind and flexibility in working with the team is important ...”

The ability to be pragmatic was another interpersonal theme that emerged. For example, how best to represent the Department and the County Board of Supervisors was described: “...to represent the then Department of Health Services and ...knowing what the current political correctness was in terms of how to represent board policy as well as department policy.” In addition, knowing one’s limits as a helping profession emerged: “I was not afraid to say when I didn’t know but would try to find out”, and “...we can’t do everything for everybody and some things are not fixable and some people are not treatable and some interventions are not doable and that’s okay. That’s okay because that’s the way the world is and we’ll do our best...”

The descriptors “confidentiality”, “fair” and being “rigidly ethical” emerged in the interviews. During the focus group, it was recommended that the term “ethics” be used to thematize this area. One area for future study that is indicated in this case is to construct a multidisciplinary ethical framework to clarify and guide practitioner behavior in integrated service settings.

In short, the inter-related themes of supportive, positive, open, flexible, pragmatic, and ethical positively relate to interpersonal effectiveness. Cultural competency is the next competency area within this domain.

Cultural Competency

Multilingual and multicultural were two interrelated themes that constitute cultural competence. Related descriptors are illustrated in Table 2.1.

Table 2.1: Cultural Competency

Themes	Descriptors
Multilingual skills	Speak language of client; speaks more than one language; [overcoming] language differences
Multicultural skills	Appreciating diversity; cultural sensitivity; respecting other culture's beliefs; understanding different cultures and customs; cross-trained culturally; educating clients to assist them in their acclimation to this country

Cultural and language barriers can impede a family's ability to have their needs met, as expressed by the following passage:

We came across a problem that was a multi-person family problem with a middle aged mentally ill sister in a household that was already stressed, even

though it was a capable woman that was in charge of the family, but because of cultural and language differences, she didn't understand how to get mental health services for her sister and it took a lot of education, explaining, rapport building, trust building, individual home visits, hospital visits, hand holding, interpreting to get that sorted out. But in the process, we got the treatment for the person that was ill that she was entitled to and needed, we got relief for the stressed family and the spin-off of that was that the children in the family then had the full attention of their mother and their home lifestyle back even though their father was out of the home. It was a noisy, complicated, difficult, time-consuming case but it resolved itself very well.

Several members of the team stated that there needs to be at least one member of the team who can speak more than one language, exemplified as follows: "I think you definitely need a bilingual clinician because we're dealing with so much Spanish-speaking or someone that speaks more than one language would be very helpful."

The ability to feel comfortable with different cultures was reinforced by one member and linked with working in the community: "... you ... need someone who's going to be comfortable working in the community with a variety of different cultures and diverse populations."

In addition, cross-training was indicated: “I think they [staff] should be cross-trained culturally, the cultural barriers of different races and different languages...”

During the focus group, members recommended that the descriptor “educating clients to assist them to acclimate to this country” be added to the multicultural theme.

The ability to speak more than one language and the ability to work comfortably with diverse cultures were considered important competency themes by this multidisciplinary team. Family and customer focused is the next competency area.

Family and Customer Focused

The ability to understand family systems and provide services that focus on the unique needs of families in convenient settings in a quick and expedient manner were clear themes that constitute the competency of family and customer focused. Themes and descriptors for this competency area are listed in Table 2.2.

One member summarized a case that illustrated the need to understand family systems, specifically focusing on working on multiple problems within one family: “... there were two members of the family that needed interventions. So, it was a multi-problem family, but that doesn’t mean that it was one person that had problems, it meant multi-people having problems.” In addition, one member felt it was important to “understand relationships that cause pain.”

Providing family focused services--where the family is at--was expressed as an important competency by one respondent:

Table 2.2: Family and Customer Focused

Themes	Descriptors
Knowledge of family systems	Dealing with multiple problem families; understanding relationships that cause pain
Family focused skills	Customer friendly; community based; patient centered service
Ability to be responsive	Responding quickly and expediently

Suppose your task was to deal with an elementary school that had a lot of at risk, highly dysfunctional kids. That would be a prime example where you could have a multidisciplinary team and then they'd have a task and the task was to get the service to those families, to be in the family space, to be on the family's porch, to be doing whatever needs to be done to make sure that no stone was left unturned for those families.

Delivering relevant services in comfortable and convenient locations constitute the family focused theme.

Several members emphasized the importance of being responsive: "I think we need to be able to respond quicker to the client's request and not wait for days or weeks" One member related this theme to employee satisfaction: "When I would see the satisfaction in the staff for being able to do something kind of quick and meaningful for

the clients that made life easier for the clients. That was extremely satisfying and rewarding” Another respondent discussed responsive in terms of connecting people: “I can get the job done and I can usually get it done with expedience. I have no desire to hang on to these people. I want to get them in and I want to get them out but I want to make sure that they’re well-connected.”

Understanding family systems, providing family focused services, and doing so in a responsive manner are perceived by the research participants as important competency themes. Multi-disciplinary teams is the next competency area.

Multi-disciplinary Teams

The attributes and functions of multidisciplinary teams emerged as important themes in this area. Themes and related descriptors are illustrated in Table 2.3.

In terms of developing multidisciplinary teams, the diversity of different disciplines working together was valued by one member: “We have an alcohol and drug counselor, we have a mental health counselor, we have a public health nurse, and I think the diversity of all the fields coming together—they can all interact—I think that’s the best thing.” Other attributes of multidisciplinary teams that were described include: “not turf or ego centered” and “broadminded”. In addition, one member stated “... they decided we were all going to be generalists ... somebody who knows how to tap the resources of the experts ... it’s like being on the internet.”

Table 2.3: Multidisciplinary Teams

Themes	Descriptors
Knowledge of team attributes	[Valuing] the diversity of different disciplines; not turf or ego centered; generalist; broadminded; work as a team
Team function skills	Rapport building; trust building; consulting; cross-training; collaborating; support and mutual respect; find common elements; problem solving; streamline services; integration across agencies

Several functions of the team were referenced by participants, such as “rapport building”, “trust building”, and so on. Consulting within the team stood out as an important team function. For example, one member said there is an

... ongoing flow of consultation within the team itself on cases that had complicated problems or a new problem would occur and would really require more than one set of interventions than what the staff member first thought of when they were dealing with the client. So, if your colleagues were not on the phone or occupied with their own cases, there would be a chance to talk to them

about the situation, and get consultation and make a decision about what the next right step would be.

Tapping into expert or specialized knowledge could occur within the team, depending on the composition and experience of team members.

Cross-training is another significant multidisciplinary team function. For example, several members described situations where they shared expertise and helped each other acquire new knowledge and skills: “I think they [team members] relied on my understanding of mental illness and what the possible responses of a mentally ill person would be ... my understanding of the County Mental Health System, which is complicated and Byzantine and hard enough to work in ... that was useful too.”

Another member indicated she acquired knowledge in the mental health and alcohol and other drug areas: “I ‘ve learned a lot from the clinicians, especially when you are in a situation where you feel uncomfortable with a client ... I have been able to recognize a lot of the different personalities like the bipolar, or people who are on drugs.” In addition, another member learned about alcohol and other drugs from another member: “I wasn’t able to attend the educational meeting on drug and alcohol but I have learned some from just talking to that clinician about some of my cases—that’s been helpful.”

The value of team member diversity and the function of cross-training was reinforced by one member as follows:

I think we need a mental health worker, an alcohol and drug services worker, and a public health nurse or something comparable right along with the child protective service worker and the Calworks [formerly GAIN] worker and that a minimum of a team of five should be in every one of our Family Resource Centers [located in each of the six aforementioned service delivery regions]. Some of these people come in with dual training. You may have a public health nurse that's also a psychiatric nurse. Okay, well that's great. But until we get to that level of cross training, I do think you're going to have to have some specialty staff that are going to be cross-trained and expected to wear the duty hat of the day. I'm the one that's on duty today and no matter what the problem is I have to problem solve the best I can and I consult with my experts. And you have to have team and case conferences to check in and to problem solve the more difficult cases.

In short, attributes and functions were considered important themes related to multidisciplinary teams. Understanding the public system is the next competency area.

The County (public) System

It was apparent from the data that multidisciplinary practitioners need to understand the public or county system in which they function. Specific themes and descriptors are illustrated in Table 2.4.

Table 2.4: The County (public) System

Themes	Descriptors
Knowledge of rules and regulations	County rules and regulations
Knowledge of services and resources	County Medical Services; Health Centers; Department of Social Services; Information Systems; Child Health and Youth Clinic; County Mental Health System; Conservator; Jail System; County Contractors; Alcohol and Drug Services; County Support Services (e.g., personnel, fiscal, purchasing, training, etc.)

One member was rather emphatic about understanding the County rules and regulations:

You have to be familiar with the county rules and regulations, what you can do and can't do within the county, what's allowed and what's not allowed ... I've been with the county 20 years, so I know a lot of the rules and regulations and some of our staff members don't know them, some of them are new, some of

them haven't had to deal with them. I think that part of knowing who to talk to, where to go; I think that has helped them get what they needed to access the system.

In addition, practitioners also need to know the array of services and resources that exist in their local public or county system:

The knowledge I really have been lacking is that the person who does this job really needs to know the social service [County] system first and foremost. They need to know the ins and outs of all these programs and that is a huge knowledge base. Not community resources—county resources. What do you provide? What's 'work first'? What's CMS? How do they get into all of these things and what do they provide and what are the ins and outs ... like the first time you apply for SSI you're going to automatically be turned down. I just assume that when you're turned down, you're turned down, and that's the end and so does everybody else, except for the people within the system. They can tell you that ... that's just normal. I'm outside the system ... I don't know that."

During the interviews, the following formal or proper (capitalized) and generic County services emerged: "County Medical Services", "Health Centers",

“Department of Social Services”, “Information Systems”, “Child Health and Youth Clinic”, “County Mental Health System”, “Conservator”, and “the jail system”.

During the focus group, team members added that it was vital for practitioners to be familiar with the array of “county contractors”, “Alcohol and Drug Services”, and “support services (e.g., purchasing, personnel & training, information systems, fiscal, etc.)”. During the focus group, members felt that practitioners can acquire this pre-requisite competency as part of a new employee orientation.

In summary, members of the PEIT feel that acquiring pre-requisite personal and professional competencies are needed for multidisciplinary practice. This requires competence in interpersonal effectiveness, cultural competency, customer and family focused approaches, multi-disciplinary team attributes and functions, and understanding the public (County) system where one practices. During the focus group, participants suggested that these pre-requisite competencies are best acquired in pre-service (academic preparation) and/or new employee orientation. Once one acquires these pre-requisite competencies, than practitioners are better prepared to develop competencies in integrated client service delivery, which is the focus of the next competency domain.

Competency Domain II: Integrated Client Service Delivery

Through review of the data, a set of competencies emerged around providing integrated services to clients and families. The following competency areas are included in this domain:

- 1) Client Advocacy and Empowerment;
- 2) Information and Referral;
- 3) Screening and Early Intervention;
- 4) Crisis Intervention;
- 5) Case Management;
- 6) Community Resources;
- 7) Specific Functions and Populations.

Client Advocacy and Empowerment

Persistence, knowledge of client benefits and how to empower others were themes that emerged in this competency area. These themes and related descriptors are illustrated in Table 3.0.

Persistence was a key theme that emerged, as indicated by the following comments: “Persistence [the key to success]. We just didn’t let go.” Similarly, another member said, “I just keep banging at the doors ... I work really hard as if it were my own problem”. And, another concurred that

... the person be a problem solver, and that they have that perseverance, they’re

Table 3.0: Client Advocacy and Empowerment

Themes	Descriptors
Ability to be persistent	Taking risks; persistence; persuasive; going outside the boundaries; getting involved and contributing; representation
Knowledge of client benefits	Health insurance (and insurance billing); Social Security Income (SSI); Medi-Cal (Medicaid); Welfare Reform
Ability to empower others	Empowerment philosophy

not ever going to give up. They stay with the problem and they stay with the client until they get an answer. And I notice that there are a lot of people that just say 'oh well, that's it and that's not it'. If it were in your own life, you'd say they [staff member] said no.

Although persistence per se is an interpersonal attribute and could be considered a pre-requisite competency, it seems clear that it is contextualized here as advocating for the client to assure access to needed services.

For example, another member discussed risk-taking, which I felt was a potent descriptor of persistence in the context of advocacy:

... you've got to be a risk taker. Sometimes you've got to take the philosophy that it's better to ask for forgiveness than permission to use common sense. I think we need to do what makes sense for this person sitting here in front of me. Okay, maybe the protocol is written one way, but that means this person's got to make three visits to x, y and z. How can I help to cut the red tape? How can I facilitate access ... and streamline service delivery for this client? Don't be afraid to test this system a little bit, to go outside the boundaries.

One member described a case she had worked on that nicely illustrates this notion of advocacy:

I just had a wonderful experience last week and it just came up against a lot of walls when a man had a stroke while he was in Mexico and hadn't paid into our system but he was a legal resident here and everyone said 'no, you've got to have this, you've got to have that', and I just keep banging at the doors ... and I work it really hard as if it were my own problem. The whole day, the whole week, whatever, I am going to be there until I get to the solution and so was able to get the man into the nursing home and the niece came by on Friday with this little gift to say thank you and they were so grateful and there have been several situations like that. I went to court with another family. The wife

needed a conservator ... a lot of people said nobody else ever called back, nobody else ever took on a problem like you have.

Having knowledge regarding client benefits, such as health insurance, emerged as a relevant theme in this competency area. For example, one member said: "I think within four or five months we had a resource ... someone there on the insurance billing staff we could call when people's benefits had gotten all confused and things like that." Another member shared a case study that acknowledged the need to know about health insurance:

There's a [case] I'm working on now ... it really touched me. This lady called and she and her husband have a small cleaning business and they have no health insurance, they only have liability insurance for their clients and she wants to become pregnant. She's been through all kinds of rejections ... but we don't know if we'll be able to help them.

Finally, empowering others was expressed as another theme pertaining to this competency area:

I come from a kind of empowerment mentality. You give a person a fish per day, but you teach them how to fish. I really teach the clients how to do their own problem solving and don't ever give up. So, I think I do a lot of teaching.

And, I believe in the inherent worth of every individual, that they all could be successful if they just know how and not to give up and they feel that from me and they're very grateful.

Persistence, knowledge of client benefits and empowerment constitute this competency area. Another core competency related to the domain of integrated client service delivery is information and referral.

Information and Referral

One member indicated that "... it would be good [for multidisciplinary practitioners] to have a class on information and referral ... [because] we do a lot of that." Specifically, it seems there are three overlapping skills one needs to acquire to do information and referral, which are thematized in Table 3.1.

The most predominant theme related to information and referral is providing information:

I think all frontline workers need to expand from ... a pocket of information and informational messages to a briefcase. I think all frontline workers need to expand their knowledge base and the messages that they are sharing. For example, a social worker assigned to Calworks can be sharing health messages around tobacco, substance use, sexually transmitted diseases, and immunizations

Table 3.1: Information and Referral

Themes	Descriptors
Ability to provide frontline information	Give concrete information; develop portfolio of messages; give health and human service messages; prevention and health promotion; consumer and family education; frontline knowledge and skills (dealing with the public)
Referral skills	Facilitate access to services; make a referral
Outreach skills	Getting (identifying and engaging) clients

if there are children—these kinds of things. Likewise, the public health nurses could be looking more at mental health issues, substance abuse issues and employment and childcare ... I think there [are] ... some minimum messages that all frontline workers could be exposed to and learn to put into practice.

Another member emphasized the referral nature of the PEIT function: "... my understanding is that our job is not long term therapy or long term anything except to make a referral to make sure people are hooked into the services that they need ..."

In addition to information and referral, outreach was considered an important element: “I just think the way we first started was hard to figure out how to go about getting the clients. You have to have that worked out pretty well to find out how you’re going to get your clients in other places.” During the focus group members added that “identifying and engaging” clients was an important preventive, outreach function of the team. Through outreach, the team can engage clients and perhaps prevent more debilitating and costly consequences. What follows is another related competency area in this series—screening and early intervention.

Screening and Early Intervention

Two key themes constitute this competency area—interview and screen—labeled as “screening and early intervention” during the focus group. These themes and their related descriptors are illustrated in Table 3.2.

According to one member, “You really need to have strong interviewing skills ...” This is evident given the confidential and comprehensive nature of this team’s screening and early intervention function. For example, one member said, “There were certain inherent components to the pilot that some programs don’t have the luxury [to provide]. Number one is that we took the time to interview people in a confidential area around family issues. And I don’t know if our programs traditionally have done that.”

Table 3.2: Screening and Early Intervention

Theme	Descriptors
Interviewing skills	Listening; information gathering
Screening skills	Understand a person's history; talk it through; help people sort out pressing need; reading people; hone in on them; interpreting; recognize; discern and delineate; determine need for specific clinical assessment or diagnosis

In addition, the screening process is comprehensive, exploring all dimensions of the client's life, to intervene as early as possible to prevent more debilitating situations from emerging:

... we looked at everything from employment, food, housing, childcare, are there children in the home? If so, do any of them have health problems or school-related issues which can open up a whole other area? Things around pregnancy, family planning, sexually transmitted diseases, domestic violence, 'are you in a relationship that causes you pain?' was a question—an opening question that we would ask. That often was very revealing. A question around coping ... if you were having difficulty coping on a daily basis ... having trouble

sleeping, trouble eating, loss of weight without trying; things of this nature that might lead off into needing a more specific clinical assessment. So, I think that there are some screening questions that people can be trained to ask They need to know their limits. They're not expected to be the clinician unless they are the clinician. But I think that there are a lot of screening messages and health and human services messages that we could give people and not just being the AIDS Case Manager or the TB Case Manager or the High-Risk Infant Case Manager. All three of those case managers should have a similar portfolio of messages to be working with the individuals or families that they are working with.

Clearly, the screener is not expected to be the clinical expert, although they may have those qualifications and credentials to perform that function.

Fundamentally, all members perform the screening function, which as one member described, involves:

... knowing or helping [the client] to discern something that they need to be concerned about and something that was more within the realm of normal growth and development or normal expectations or realm of normalcy ... I was reassuring in helping them to delineate if they needed to make a referral or take some kind of action.

And, during this process, the screener may need to refer the client to another member of the team who can perform a more formal “clinical” assessment: “... I interview them and find out what their problems are and if there are any other problems that relate to the mental [health] or alcohol or pregnancy or health issues. Then I call the clinicians in and they take over to do the [clinical] assessment.”

Sometimes, members were contacted by other programs to conduct a general screening or formal clinical assessment: “There were times when there were calls from the Valley DSS office next door that they had concern about or problem that they found a little bit outside their regular responsibilities and didn’t know how to solve and would call on us to intervene in some way.”

Interviewing and screening are themes pertaining to the competency area screening and early intervention. Crisis intervention is the focus of the next competency area.

Crisis Intervention

Although only one theme constitutes this competency area, it was perceived as an important and distinct area by both the PEIT team and researcher. Specific descriptors are listed in Table 3.3.

Although informants did not use the word “crisis intervention”, I believe the following passage by one member aptly defines this competency area:

Table 3.3: Crisis Intervention

Theme	Descriptors
Crisis intervention skills	Suicide; coping; stress; sexual abuse; domestic violence; medical emergencies; art of honing in on primary need; homeless/housing

... I think a skill [is] being able to try to hear people's distress and help them sort out what is the most pressing need and at the same time understand if there's anything that can be done for that pressing need in order to bring some positive resolution and some feeling of hope for people that are in distress.

Listening to the client and helping them to come to some kind of positive resolution are key elements of crisis intervention.

Another member provided a detailed case study that further illustrates this competency area:

... There was this man that came in—just came in off the street to the front office ... The receptionist routed him to me and she said there's somebody here who's really agitated, he's really upset, would you talk to him, he wants to talk to a counselor ... He started ranting and raving and telling me how he was at the end of his rope and if somebody just said the wrong thing to him he was

going to do something and he had thought about suicide ... He just felt that he was at the end and he just had enough. I just sat there patiently and I listened to him and I was afraid to say the wrong thing and I just wanted to let him let it all out and after he calmed down a little bit, then I told him ‘I’m glad you came in—sometimes it’s good to have someone to talk to’ and then I told him ‘there is somebody here who could probably help you with some of the things you told me about right now’. And then I called one of the clinicians ... he gave him more information and asked him more things. And after it was all said and done he gave us both a hug and he said you know I’m really glad that I had someone to listen to me. After he left, he looked like he was a lot calmer and a lot more happy so I felt good because I thought that what would have happened if just one more person had not listened to this guy. What would he have done? Would he have committed suicide? Would he have done something to somebody?”

Again, listening appears to be a key behavior in performing crisis intervention.

During the focus group, team members validated “crisis intervention” as the label of this competency area and added specific examples, including “how to respond to domestic violence situations”, “how to deal with medical emergencies”, “the ‘art’ of honing in on the primary need”, and “assisting the homeless with securing emergency housing/shelter”. The next competency area to be described is case management.

Case Management

Educating clients and families, performing ongoing case monitoring and conducting follow-up services were all pertinent themes related to case management, as indicated in Table 3.4.

In terms of case management overall, one member opined: "... as far as knowledge goes, probably 3-5 years experience in public health doing case management with families [is helpful]. [Team members] should have case management

Table 3.4: Case Management

Theme	Descriptors
Education skills	Educating and explaining
Case monitoring skills	Case monitoring; team and case conferences; touching base with the client; family focused (visiting where client needs you, e.g., home, hospital, school, etc.)
Follow-up skills	Follow-up

and evaluation skills necessary to do case management in health promotion and prevention ...”

A fundamental case management skill involves education: "... educating and standing behind the other members of the family to explain to them how the system worked ... "

Case monitoring was another element of case management that emerged, particularly home visiting: "There were components of our pilot that involved case management that I was comfortable with and could mentor and help those who maybe were not used to doing case management, especially the home visiting piece of it." During the focus group, members wanted it emphasized that case management needs to be family focused—you go to where the client or family is, which reflects this emphasis on home visiting. Other places team members may need to go include hospitals, schools, etc.

Follow-up was another important feature that members discussed: "... sometime during the day I do my follow-up as needed, either by phone or sometimes I might even make a home visit." Another member stated:

We also built in a follow-up component. Everyone who was referred, we attempted to follow-up. Now we weren't always successful. Sometimes we would lose the client, we couldn't make contact but we would call them back or make a home visit or send a letter but we would attempt to try to provide some follow-up and determine outcomes. If they needed resources for food, if they needed childcare resources, if they needed a primary care provider.

Educating, case monitoring and follow-up are integral components of case management. Knowledge of community resources is the next competency area related to the domain of integrated client service delivery.

Community Resources

Knowing the resources of the community you are working in emerged as an important theme. Although similar to the competency areas “understanding the public system” (p. 52) and “client advocacy and empowerment” (p. 55), PEIT members felt that acquiring competence with community resources is a unique and lengthy learning process and, therefore, needed its own competency area. Related descriptors are illustrated in Table 3.5.

One member described her distress for not knowing enough about the North Inland community:

I was very distressed about my lack of background in community resources because I had not worked in that community and my network of people that would tell me things and answer questions for me was only in the mental health system. So when I had a question that was over my head in another area then I just had to pass it on to my colleagues of course and I tried to answer questions for them in the mental health area but still just not having a grasp of the

Table 3.5: Community Resources

Theme	Descriptors
Knowledge of community resources	Knowing your community resources; services for the developmentally disabled (e.g., Regional Center); hospitals (e.g., Children's Hospital); board and care homes; transportation; food; glasses; childcare; housing; shelter (homeless); employment; counseling services; school services (middle school program and school nurse program); community health clinics; alcohol and drug treatment centers; juvenile diversion programs (e.g., Choice); education (e.g., ESL)

resources that we needed to know about. It took probably about four or five months for me to get that and that was hard. I wouldn't want to do that again.

Another member described her personal journey in becoming familiar with community resources:

I spent quite a bit of time going out into the community as often as I could to get to know my community because I'm not a part of this area and I don't know what the percentages of the different ethnic groups are and even the services. It was important for me to go out and see what's really going on rather than to just stay here in my office. If I want to refer someone somewhere I want to feel comfortable that that's a fit. So, it's knowing your resources.

During the interviews and focus group, members made reference to a variety of generic and specific (in parentheses) community resource categories that need to be part of a training program in community resources, such as "housing (board and care homes, shelters)", "employment", "education", "counseling services", "schools (middle school program, school nurse programs)", "community health care clinics", "alcohol and drug treatment programs", "juvenile diversion programs", "childcare", "food", "transportation", "hospitals" and services for the "developmentally disabled". The next competency area was particularly significant in terms of its scope and relevance—knowledge of specific functions and populations.

Specific Functions and Populations

Basic, technical knowledge pertaining to specific health and human service functions and client populations became a significant theme that emerged from the data. The PEIT identified several areas that multidisciplinary practitioners need to know in

order to integrate services across programmatic and disciplinary boundaries. In Table 3.6, I listed the specific themes and descriptors related to this competency area. Again, some of the descriptors overlap with the competency area “community resources” (p. 69), yet the PEIT considered resources in this competency area specialized and/or contextualized for specific functions and/or populations.

Knowledge regarding mental illness emerged as an important theme. One member expressed a need to have more training regarding psychotic diseases:

Table 3.6: Specific Functions and Populations

Themes	Descriptors
Knowledge of mental health	Developmental disabilities; affective disorders (e.g., bipolar disorder); psychotic diseases (e.g., schizophrenia); personality disorders (behavioral patterns); sleeping and eating problems
Knowledge of alcohol and other drugs	Substance use and abuse; alcohol and drug user; alcohol and drug counseling; alcohol and drug services; recovery continuum; tobacco

Knowledge of physical health	Normal growth and development; physical disabilities; health problems; basic diseases; health exams; HIV disease / AIDS; sexually transmitted diseases; tuberculosis
Knowledge of child & family health & well being	Childhood disability; family planning; pregnancy; prenatal care; postpartum; well baby exams (high risk infants); immunizations; speech therapy; school issues; behavior problems; parenting skills; holistic family systems approach; child protective services (abuse and neglect and foster care)
Knowledge of older adults	Dementia (Alzheimer's); support systems; unique health status; elder abuse; continuum of services and resources (e.g., meals on wheels; senior centers, etc.)

“I hadn’t had a lot of experience recently with people that were psychotic, so I didn’t feel very comfortable. But I did give the family some referrals and some information they could try. It probably would have been helpful if I had some kind of training or recent training in the different psychotic diseases.”

In addition to mental illness, having knowledge regarding alcohol and other drugs was relevant, as evidenced by one member’s case summary:

There was this guy who got out of jail and was an alcoholic and drug user and showed up one day needing help. We were able to put him with the clinician and he got the needed services and came in one day after that and he had fallen off the wagon and was really kind of irate.... we had to do one of those tough love type of situations. We can’t do it if you don’t want to do it.

One member summarized quite succinctly what multidisciplinary practitioners need to know regarding alcohol and other drugs: “... being able to understand a person’s history ... of drug and alcohol use and their place in the recovery continuum.”

In terms of general physical health, one member stated that it’s important to know “... some of the basic diseases ... if the members of our team come to me and have a question I can usually answer that or refer them where they need to go.” Other physical health areas that were mentioned during the interviews were “normal growth

and development”, “physical disabilities”, “HIV / AIDS”, “tuberculosis” and “sexually transmitted diseases”.

Members validated the value of possessing knowledge regarding child and family health and well being. For example, knowledge regarding family planning and pregnancy was mentioned by one member: “... my knowledge regarding the pregnant woman, postpartum and children—because that was my expertise ... that I practiced for many years.” Child development was mentioned by another: “I’ve worked a lot with babies and understanding their development.” In addition, postpartum was also described:

There were some cases of women that were pregnant and had their babies and then had, in fact, difficult birth experiences and difficult postpartum. Without the nurse’s input, nobody would have understood what was going on there and then what to recommend to the patient. Whether they recommend they go back to the doctor, whether they recommend that they just deal with the side effect symptoms or what this was all about.

Other child and family health-related areas that were referenced by members included awareness of “childhood disabilities”, “prenatal care”, “immunizations”, and “speech therapy”. During the focus group, members added other areas that they felt pertained more to “well being”, such as understanding “common behavior problems”,

“parenting skills”, “holistic family systems approach”, and “child protective services (abuse and neglect and foster care)”. Moreover, it is because of these additions that the term “well being” was added to the heading of this particular competency area.

Acquisition of knowledge regarding the unique needs of older adults was referenced by one member: “... I think I’ve learned a lot about the elderly ... such as dementia.” During the focus group, there was a strong consensus to add more specific information to this competency area, including “understanding Alzheimer’s disease within the context of dementia”, “familiarity with support systems for older adults (including knowledge of specific resources and services for older adults, such as meals on wheels, senior centers, etc.)”, “recognizing the unique health status of older adults”, and “recognizing and responding to elder abuse”.

In short, basic knowledge of mental health, alcohol and other drugs, physical health, child and family health and well being, and older adults are necessary for multidisciplinary practice. General knowledge of core health and human service functions and populations enables practitioners from diverse disciplines to recognize specific needs and refer accordingly.

In summary, integrated client service delivery is perceived by the research participants to be an important competency domain. Specific core competency areas related to this domain include: client advocacy and empowerment, information and referral, screening and early intervention, crisis intervention, case management,

community resources, and knowledge of specific functions and populations.

Competencies needed to develop and operate multidisciplinary teams or programs is the focus of the next domain.

Competency Domain III: Program Operations

It was clear from the interviews and focus group that a specific set of competencies is required to develop and implement a multi-disciplinary team or program, at least as perceived by the PEIT. The following core competency areas are categorized in this domain:

- 1) Planning and Development;
- 2) Management and Leadership;
- 3) Community Collaboration;
- 4) Administrative and Technical Skills.

Planning and Development

Pre-implementation and development were apparent themes in this competency area. These themes and related descriptors are indicated in Table 4.0.

Planning was an important pre-implementation skill in the design and operation of the PEIT pilot program, as described by one member: “The pre-implementation phase was a series of planning meetings and deadlines and negotiating with a number of

Table 4.0: Planning & Development

Themes	Descriptors
Pre-implementation skills	Meetings; deadlines; negotiating;
Development skills	Develop [client] screening questionnaire; write job descriptions; design program objectives; being involved in all aspects of the program; develop a resource manual; write policies; develop protocols; forms development; evaluation (determine outcomes);

different committees in the Department of Health Services to determine how we were going to implement this pilot.” Negotiation, as a part of the planning process, was amplified: “We negotiated with the co-located staff over space, over use of the copier machine, over use of the coffee room and paying coffee dues and ...”

The design of a client screening questionnaire was a significant development task, around which all other program operations were designed. In addition, “... we had to do a job description and then we also had to do our objectives. This is what was so unusual about this job is we had to kind of start from scratch and decide what exactly we wanted to accomplish.” Another unique element about the development of

the pilot was that it was a collaborative, team effort: "... I think being involved in all aspects of the program helped ... I wanted to understand more and be more involved."

Team involvement in program development was attributed to leadership by one member:

We had a leader who believed we should all be involved, no matter what position we played, from gathering data, to touching base with the client.

[There are] certain things you can't let other people do because of licenses. But we do have a leader who believed that we have to work together as a team and in order to make that team the best it could be, that we all knew something, we all kind of got a little piece of the pie...

Other skill areas pertaining to development that were referenced in the interview transcripts included "developing a resource manual", "writing policies and procedures and developing protocols", and "conducting evaluations to determine outcomes" (which would begin a new planning and development cycle). In addition to planning and development, management and leadership emerged as another core competency.

Management and Leadership

Management and leadership were distinct yet overlapping themes, as the reader will note in Table 4.1

Accountability was a significant management theme that related to this competency area. For example, one member said:

Table 4.1: Management and Leadership

Themes	Descriptors
Management skills	Accountability; prioritize; meet deadlines; research; run and attend meetings; recruiting and hiring staff
Leadership skills	Train staff (role playing); coaching; modeling; conducting performance reviews

I had less than 90 days from time of appointment into this position to bring up and implement this pilot. So it was a very tight time frame with a lot of deadlines determining how to recruit and select staff when we had no budget ... I guess there were times that I felt like whether or not this even happened and if it succeeded or failed really kind of rested on my shoulders ... I never felt unsupported but I did feel accountable. And sometimes it was that accountability where I felt that I was out there on a string by myself.

Other skills that were referenced include “prioritizing tasks”, “setting and meeting deadlines”, “researching information” and “running and attending a variety of meetings”.

Leading staff was another theme that emerged: "... there was some hand-holding that needed to occur and some coaching and listening and saying things will get better ... seeing that the staff were cross trained." In addition, "recruiting and hiring staff" and "modeling behaviors" were related statements. During the focus group, the members decided to add "conducting performance reviews" to this area.

During the focus group, the terms "management" and "leadership" were validated as appropriate cover terms for this competency area. However, we did not address the issue of who needs to acquire these competencies and who is ultimately accountable for management and leadership tasks. This raises the question "who needs what", and the answer has implications for collaborative management and leadership, which I will address in more depth in Chapter Five. Now, I turn to the next competency area in this domain—community collaboration.

Community Collaboration

I originally placed this competency area within the planning and development area. However, during the focus group, members felt strongly that this is a distinct and separate competency area. Specific descriptors are listed in Table 4.2.

The distinctiveness of community collaboration was reinforced in an interview when one member described her lack of knowledge in this area:

I think community capacity building and community development is a specialty

Table 4.2: Community Collaboration

Themes	Descriptors
Community collaboration skills	Networking; field trips; working in other agencies; community partnership meetings

unto itself and it is not necessarily an area of specialty of mine. I've worked with the community. I think I can be a pretty open collaborator but I did meet with some people who had those skills to try to better increase my skill in that area.

Community partnership meetings and field trips were described as specific community collaboration strategies:

... there were days when we had meetings that we had scheduled—community partnership sort of meetings—which were usually at noon and went over until 2:00 in the afternoon... There were times when we scheduled field trips for ourselves to visit other agencies. Those would happen either in the morning or the afternoon at the convenience of the other agency to familiarize ourselves with what the resources were in the community ... without having met the people at the agency and seeing their set up and understood their criteria for their clientele, we were still ignorant.

In addition, team members actually “worked in other agencies”, where they would administer and/or review Client Screening Questionnaires, conduct screenings, provide information and referral, and so on. Administrative and technical competencies are the focus of the next competency area in this domain.

Administrative and Technical

Skills in documentation, computers and resources emerged in this area. These themes and related descriptors are illustrated in Table 4.3.

Table 4.3: Administrative & Technical

Themes	Descriptors
Documentation skills	Scanning forms and running reports; typing; taking minutes; filing; running tally of interventions; statistics
Computer skills	Computer skills; computer program design
Resource acquisition skills	Resource acquisition (e.g., office supplies)

Members described documentation or various forms of written communication as a competency pertaining to the administrative and technical competency area. One member said: “I take minutes and notes ... if they need me ... I’ll sit in.” Another

member shared: "... I gave a lot of effort to organizing the monthly report statistics and that took a couple of days of work towards the end of the month." Still another member said, "There was a lot of statistics that was being taken all the time. You had to keep track of this and that there's a lot of paper work ..."

Knowing how to use a computer was emphasized as an important technical skill. One member described the importance of "... the various [computer] systems and knowing how to ... access. That helps tremendously because you can hook up and ... everybody's doing that cross computer linkage." Furthermore, one member described the value of computers for integrating service delivery:

I think computer skills are going to be a big thing. We all need to know how to access the system and be able to pull up a client's folder to see who they've talked to, who they haven't, what services they have, what services they might need, what kinds of follow up ... instead of all these silos. We need to be able to connect welfare ... [for example] these people have Medi-Cal so they can have these services, we can send them here, we can't send them there.

In addition to documentation and computers, "resource acquisition (e.g., office supplies)" was added during the focus group.

In the administrative and technical area, skills in documentation, computer skills and resource acquisition were referenced.

In summary, program operations emerged as a third competency domain. Specific core competencies include: planning and development, management and leadership, community collaboration, and administrative and technical skills. Accountability and responsibility for program tasks is an important variable to consider when deciding who needs to acquire one or more competencies in this domain. I will discuss this issue in more depth in Chapter Five. Organizational competencies emerged as a distinct domain, which is the focus of the next and final section.

Competency Domain IV: Organizational Competence

After several reviews of the competency areas (following the focus group session), the researcher felt that one group of data did not have a significant relationship with other competency areas. This will become evident to the reader after reviewing the themes and descriptors in Table 5.0 and related quotes.

Four themes emerged from the data that relate to identifying and resolving challenges: professional differences, resources, processes and misperceptions.

Professional differences were considered a predominant organizational challenge. For example, one member explained the challenge of professional differences in terms of accepting gifts from clients:

They [staff] each come with their own strengths and weaknesses and their own

Table 5.0: Identifying and Resolving Challenges

Themes	Descriptors
Professional differences	Differing professional approaches; clarifying professional / client Boundaries
Lack of resources	Small, distracting facility; lack of budget
Problematic processes	County's slow response to program needs; wasting time waiting in other agencies
Misperceptions	Territoriality among staff; confused middle management; people confused about PEIT function; clients assume PEIT has resources on hand

program biases. For example, it was interesting at Christmastime because _____ started on her own doing this little collection for one of the families. Not money, but used clothing and things of this nature. It was a large family and she started to put together this little Christmas box and was asking other members of the team [for donations]. _____ and _____ said no, that's absolutely no, no, no. We were always told

up front, you don't give to the family ... material things. You're blurring the line between the professional and the client ... we had quite a bit of discussion about professional background and training and the role of the professional and where there might be boundaries and whether or not it was comfortable to cross those boundaries in this kind of setting.

One member attributed professional differences to interaction styles: "... different professional groups have been trained in different styles of interacting so those sometimes clash within the group. Sometimes we had to sort those out and explain what the rationale was behind how we were doing things with the client."

Lack of resources was another theme, specifically pertaining to budget, facility and client services. For example, during the pre-implementation phase of the PEIT pilot, one member said:

I was always having to negotiate and the biggest hurdle was getting Deputy Directors to either loan me staff to do this pilot and that was hard because ... that meant something else within their program wasn't going to get done or wasn't going to get done as well or two other people were going to have to pick up the work of that person ... The Board of Supervisors said that we could try to do things differently within the Department of Health Services but it would be with no new County money... But probably budget issues—being able to get

money for the appropriate scanning equipment for data collection, for development of our forms ... for modular furniture ...[was a challenge]”

Several members identified lack of space as another challenge. For example, one member felt “... kind of squeezed into a small office space, that was kind of hard.” This was echoed by another member who said: “I think that the space being so small was a big problem. We wanted to be close and bond with each other and learn from each other so we didn’t want to leave each other really ... [however] it was distracting for some people to be so close...”

The lack of client services was expressed as another resource challenge by one member:

... the reason a lot of our clients have the needs that they do is that the resources aren’t there in the community to meet those needs. So when you ask these questions of people and you gather this information, we were not always in a position to be able to do anything about it except to recognize that, yeah, here’s another person who doesn’t have transportation, here’s another person who needs to be employed ...

Frustration with current organizational processes was expressed by some members. One member discussed a specific work process that results in wasted staff time:

On a typical day I position myself at a site where people are going in, it might be CMS, could be DSS, could be here in the CHYC clinic, and wait for someone to need me. To me that's wasted time and difficult. So, I think that the way that this is arranged could be better ... If I have to go to CMS and sit for four hours waiting for someone to call that's not a good use of my time and I can spend a whole morning just sitting and waiting and not see one client ... I get terribly bored and I'm not happy at my job if I'm not utilized ... people just sit and wait and talk and eat and I've gained ten pounds since I've been here.

Another member described the County's slow process for responding to PEIT equipment requests: "It took awhile for us to get our computers up and took awhile for us to get the phones that we really needed working."

There were some misperceptions that hindered the effective functioning of the program. One misperception was on the part of clients: "I think that a lot of the places where we do interviews, sometimes they're confused as to what our real function is, what is it that we do. They think that we have a bag of groceries ... since we're asking these types of questions then we must have our own resources on hand."

Another misperception led to territoriality among colleagues: "... they'll [colleagues] say 'what are you doing with my client'? It's territorial." Another member relayed comments she received from a DSS worker: "... who are you and why are you talking to my client? Or, you can't come into that orientation session unless you have permission from my supervisor ... But that was part of their ... misunderstanding, lack of information, lack of training." One member offered ideas for responding to territoriality:

... there's no more point in being territorial. There's not going to be any reward for being territorial--that's an unacceptable approach. If that gets into the corporate culture, then the rest is easy ... learning to work together effectively, I believe, starts at the administrative level. It does not start at the line worker's level. This is very much a modeling situation ...

Another area of misperception is the current confusion experienced by middle managers: "...there are people in the middle-management level who are very confused right now. They would like to work together because they do see it would be more practical but they don't know where their rewards are going to come from."

In short, professional differences, lack of resources, problematic processes and misperception and confusion were identified at the time of this study as challenges by the PEIT. I framed this domain "organizational competence" since the related

challenges are systemic in scope, and beyond the sole control or responsibility of the PEIT. Resolution of the problems will undoubtedly require a larger, organizational or community intervention.

Summary

In a review of the data from the interviews and focus group, four competency domains and related competency areas emerged: 1) Pre-requisite Personal and Professional Competencies (interpersonal effectiveness, cultural competency, family and customer focused, multidisciplinary teams, and the county system); 2) Integrated Client Service Delivery (client advocacy and empowerment, information and referral, screening and early intervention, crisis intervention, case management, community resources, specific functions and populations); 3) Program Operations (planning and development, management and leadership, community collaboration, and administrative and technical); and 4) Organizational Competence (identifying and resolving challenges).

In the next chapter, I elaborate on this summary by framing this data into competency statements, for multiple organizational applications. I also discuss the implications of these findings in light of the literature reviewed in Chapter Two. I then present a dynamic model that contributes to our current understanding of organizational

learning. I then conclude this dissertation with a discussion of this study's limitations and related suggestions for future research and development.

CHAPTER FIVE
SUMMARY, IMPLICATIONS AND
RECOMMENDATIONS

Introduction

In the previous chapter, I provided a comprehensive analysis of the data collected from individual interviews and a follow-up focus group. The data revealed four competency domains and one or more competency areas within each domain.

In Chapter One, I introduced the issue: In response to a variety of forces, publicly funded health and human service systems are becoming more integrative, requiring practitioners to acquire new competencies. However, a review of the literature indicated a lack of knowledge in this area. The following research question was therefore presented: “What are the core multidisciplinary competencies perceived to be essential among direct service practitioners in an integrated public health and human service system?”

In this chapter, I concluded this descriptive study with a response to the research question, and related recommendations. First, I framed the competency domains and areas into competency statements, for multiple organizational applications. Second, I discussed the implications of these competencies in light of the literature reviewed in Chapter Two. Third, I presented a dynamic multidisciplinary competency model, designed to promote organizational learning to facilitate the integration of health and

human services. And, lastly, I concluded by discussing the limitations of this study and offered suggestions for future research and development.

Multidisciplinary Competencies

Competencies, are in essence, the knowledge, skill and attitude *clusters* that enable one to perform a certain role, job, or task (American Society for Training and Development, 1983). According to McLagan (1982), “We define jobs and roles in terms of tasks and responsibilities, but we describe—and develop—people in terms of competencies” (p. 20).

In this section, I framed the competency domains and related competency areas into competency statements. These statements are built from the competency themes presented in the previous chapter. The competency statements are behavioral descriptors; such descriptors enable us to observe whether or not individuals, teams and organizations are demonstrating a given competency area or domain.

A. Domain I: Pre-requisite Personal and Professional Competencies

1. Interpersonal Effectiveness: Demonstrates interpersonal effectiveness by displaying the following behaviors: supportive, flexible, positive, pragmatic, ethical and open minded when interacting with clients, families and co-workers.

2. Cultural Competency: Demonstrates cultural competency through the ability to work comfortably with persons from diverse cultures and/or the ability to speak more than one language.

3. Family and Customer Focused: Demonstrates the ability to understand complex family systems, provide family focused services in locations convenient and comfortable for consumers, and does so in a responsive manner.

4. Multidisciplinary Teams: Demonstrates the ability to be a team player with an understanding of the unique attributes and functions of multidisciplinary teams.

5. The County (public) System: Demonstrates knowledge of the local (e.g. San Diego) County system, including rules and regulations and the vast array of available public resources and services.

B. Domain II: Integrated Client Service Delivery

1. Client Advocacy and Empowerment: Demonstrates persistence when linking clients with services, knowledge of client benefits and an ability to empower others.

2. Information and Referral: Demonstrates an ability to provide a wide range of information, referral and outreach services.

3. Screening and Early Intervention: Demonstrates comprehensive interviewing and screening skills that promote prevention and early intervention.

4. Crisis Intervention: Demonstrates effective listening and support behaviors that result in positive resolutions.

5. Case Management: Demonstrates an ability to educate clients and families, perform case monitoring and follow-up services.

6. Community Resources: Demonstrates knowledge of community resources in diverse areas, such as education, employment, housing, transportation, health, child protection and well being, financial, food and legal support services.

7. Specific Functions and Populations: Demonstrates a basic knowledge pertaining to specific health and human service functions (mental health, alcohol and other drugs, physical health, child & family health and well being) and populations (children and youth, adults, older adults) necessary to integrate services.

C. Domain III: Program Operations

1. Planning and Development: Demonstrates an ability to participate in the planning and development of integrated, multidisciplinary service delivery.

2. Management and Leadership: Demonstrates management skills through accountability and leadership skills through effective staff support.

3. Community Collaboration: Demonstrates an ability to develop and maintain community partnerships and collaboratives.

4. Administrative and Technical: Demonstrates skills in completing various forms of written documentation, computer operations and resource acquisition.

D. Domain IV: Organizational Competence

1. Identifying and Resolving Challenges: Demonstrates an ability to participate in the identification and resolution of challenges and barriers that impeded the effective delivery of integrated services.

These competency statements describe the core competencies (specific behaviors) required for individual, team and organizational performance in an integrated health and human service system. They have multiple organizational applications. Below, I identified four possible applications:

- 1) **Policy Development:** The competency statements may provide insight regarding health and welfare reform. More specifically, multidisciplinary competencies in an integrated setting may inform the policy development process to guide discussion and decision making processes regarding managed care applications and culture change required for implementation of Temporary Assistance to Needy Families.
- 2) **Organizational Development:** The competency statements can serve as a tool for assessing organizational performance and identifying and resolving organizational challenges. Some challenges require an educational

intervention; others require structural or technical changes, such as policy development/revision, resource acquisition, and so on.

- 3) **Training and Curriculum Development**: The competency statements can serve as the foundation for developing continuing education curricula. Training and development personnel could refer to the competency themes and descriptors in the previous chapter as a starting point for writing learning objectives and determining learning content, selecting instructional methods/media, evaluation methods, and so on. Additional research/needs assessment is indicated to assure that curricula are adapted to meet the unique needs of learners;
- 4) **Performance Appraisal**: In order to facilitate change in individual, team and/or organizational performance, it is critical that performance standards are measurable and clearly communicated to all employees and integral to an organization's performance appraisal processes. The core competencies can be framed into performance standards and scaled into performance ratings. For example, behaviors for each competency area can be specified for outstanding, above standard, standard, improvement needed and unsatisfactory;
- 5) **Rewards and Recognition**: To support and reinforce the acquisition and display of core competencies, organizational rewards must be delivered in a

timely fashion when desired behaviors are displayed by individuals and teams. This enables employees to know what behaviors are valued and expected. Reward and recognition programs can be both monetary (bonuses, pay for performance, etc.) and non-monetary (plaques, mugs, gift certificates, public acknowledgement, etc.). An organization's menu of rewards needs to be responsive to what is valued by individuals and teams in a given organizational context.

The preceding applications will help organizational systems develop policy, define performance behaviors, assess individual, team and organizational strengths and needs, design responsive training and organizational development programs, and deliver rewards to reinforce desired performance. In the next section, I discussed the implications of these competencies for current research.

Contribution to Research

In Chapter Two, I reviewed relevant literature and identified three primary areas related to this study: team effectiveness, interprofessional collaboration and cross-functional knowledge and skills. I concluded that the current state of the literature indicates that our research to date is fragmented, limited in scope and empirically inconclusive. In this section, I highlight competency areas that this study has reinforced as well as new contributions.

In Table 6.0, I have constructed a “Multidisciplinary Competency Research Matrix”. The table summarizes relevant literature from Chapter Two into four columns: research category, author(s), year of publication, and relevant competency findings. In the fifth column, I listed what I perceived to be related multidisciplinary competency areas identified in this dissertation. This demonstrates how this dissertation relates to prior research. Some competency findings of prior research do not appear to significantly relate to one or more competency themes identified in this study, arguably because the competency area is highly specialized and perhaps not a multidisciplinary competency area, such as epidemiology or pharmacology. In these cases, I wrote “no direct relationship.”

Interestingly, all seventeen competency areas identified in my study have a direct relationship to prior research. I believe this reinforces prior competency findings and strengthens the validity of my findings. As the reader will note, some multidisciplinary competency findings in this dissertation were more applicable than others. What follows is a descending list of competency areas with the frequency in parenthesis:

- 1) Specific functions and populations (15);
- 2) Multidisciplinary teams (8);
- 3) Interpersonal effectiveness (6);
- 4) Management & leadership (6);

Table 6.0. Multidisciplinary Competency Research Matrix

Research Category	Author(s)	Year	Competency Findings	Related Multidisciplinary Competency Area(s)
Team Effectiveness	Johnson & Johnson	1997	<ul style="list-style-type: none"> • Small team skills • Accountable 	<ul style="list-style-type: none"> • Multidisciplinary teams • Management & Leadership
Interprofessional Collaboration		1992	<ul style="list-style-type: none"> • Group process • Communication Skills • Positive interdependence / common goal • Promote team success / process team functions • Value other professionals/profession • Able to explain perspectives of other professions • Overcome jargon barrier • Personality characteristics • Collaboration 	<ul style="list-style-type: none"> • Multidisciplinary teams • Interpersonal Effectiveness • Multidisciplinary Teams • Multidisciplinary Teams • Multidisciplinary Teams • Specific disciplines and populations • Specific disciplines and populations • Interpersonal effectiveness • Community Collaboration
		1997	<ul style="list-style-type: none"> • Leadership & accountability • Teams • Customer oriented • Diversity • Policy 	<ul style="list-style-type: none"> • Management & leadership • Multidisciplinary teams • Family & customer focused • Cultural competency • Planning & Development
		1997	<ul style="list-style-type: none"> • Interpersonal communication • Teamwork • Leadership • Community Collaboration 	<ul style="list-style-type: none"> • Interpersonal effectiveness • Multidisciplinary teams • Management & Leadership • Community collaboration

Cross Functional Knowledge and Skills: Discipline-Specific Studies	Fergusson & Diserens	1996	<ul style="list-style-type: none"> • Nursing – Pediatric oncology 	<ul style="list-style-type: none"> • Specific disciplines and populations – children and family
	Hekelman, et al; & Timms	1995	<ul style="list-style-type: none"> • Nursing – Gerontology 	<ul style="list-style-type: none"> • Specific disciplines and populations – older adults
	Carter & Axford	1993	<ul style="list-style-type: none"> • Nursing - Computers 	<ul style="list-style-type: none"> • Administrative and technical
	Pereles & Russell	1996	<ul style="list-style-type: none"> • Medicine – Gerontology 	<ul style="list-style-type: none"> • Specific disciplines and populations – older adult
	Hoffman, et al	1993	<ul style="list-style-type: none"> • Medicine – Genetics / Tests 	<ul style="list-style-type: none"> • <i>No direct relationship</i>
	Browne, et al	1996	<ul style="list-style-type: none"> • Social Work – New health directions 	<ul style="list-style-type: none"> • Specific disciplines and populations – physical health
Cross Functional Knowledge and Skills: Multidisciplinary Studies	Henry, Sullivan & Campbell	1993	<ul style="list-style-type: none"> • AIDS / HIV 	<ul style="list-style-type: none"> • Specific disciplines and populations – physical health
	Spencer, Shadick & Kasik-Miller	1996	<ul style="list-style-type: none"> • Type II Diabetes 	<ul style="list-style-type: none"> • Specific disciplines and populations – physical health
	Gravitz	1980	<ul style="list-style-type: none"> • Management 	<ul style="list-style-type: none"> • Management & Leadership
	Silverstone	1991	<ul style="list-style-type: none"> • Adult depression 	<ul style="list-style-type: none"> • Specific disciplines and populations – mental health
	Taylor, Bradley & Warren	1996	<ul style="list-style-type: none"> • Empowerment • Communication • Assessment • Community and service networking • Facilitation of services 	<ul style="list-style-type: none"> • Client advocacy and empowerment • Interpersonal effectiveness • Screening & Early Intervention • Community Collaboration • Information and referral

Multidisciplinary, continued	Taylor, et al, continued	1996	<ul style="list-style-type: none"> • Community living skills and supports • Education • Training and self-development • Advocacy • Vocational • Educational and career support • Crisis intervention • Organizational participation • Documentation 	<ul style="list-style-type: none"> • <i>No direct relationship</i> • Case management • Management & Leadership • Client advocacy & empowerment • <i>No direct relationship</i> • Management & Leadership • Crisis intervention • Identifying & resolving challenges; Planning & Development • Administrative and technical
	Rodriguez	1997	<ul style="list-style-type: none"> • Academic foundation • Communication • Health care systems • Employability skills • Legal and ethical responsibilities • Laboratory testing • Safety practices • Assist physician 	<ul style="list-style-type: none"> • <i>No direct relationship</i> • Interpersonal Effectiveness • The county (public) system, Community resources, and Specific disciplines and populations • <i>No direct relationship</i> • Interpersonal effectiveness, The county (public) system • Specific disciplines and programs – physical health • <i>No direct relationship</i> • <i>No direct relationship</i>

Multidisciplinary, continued	Rodriguez, continued	1997	<ul style="list-style-type: none"> • Health maintenance • Physician's office • Intra-team communication • Patient monitoring • Patient mobilization • Pharmacology 	<ul style="list-style-type: none"> • Specific disciplines and populations - physical health • <i>No direct relationship</i> • Multidisciplinary teams • Case management • <i>No direct relationship</i> • <i>No direct relationship</i>
	Lefkarites, McGann & Yeaker	1995	<ul style="list-style-type: none"> • Acute outbreak investigation • Epidemiology • Government regulations and public health • Law and public health • Interventions for health behavior • Community mental health • Nutritional assessment • Maternal and child health 	<ul style="list-style-type: none"> • <i>No direct relationship</i> • <i>No direct relationship</i> • The county (public) system • <i>No direct relationship</i> • Specific disciplines and populations - physical health • Specific disciplines and populations - mental health • <i>No direct relationship</i> • Specific disciplines and populations - child & family health and well being

- 5) Community collaboration (3);
- 6) Client advocacy and empowerment (2);
- 7) Case management (2);
- 8) Planning & development (2);
- 9) Administrative & technical (2);
- 10) Cultural competency (1);
- 11) Family & customer focused (1);
- 12) Information & referral (1);
- 13) Screening & early intervention (1);
- 14) Crisis intervention (1);
- 15) Community resources (1);
- 16) Identifying and resolving challenges (1).

A significant relationship exists among three competency areas: specific functions and populations, multidisciplinary teams and interpersonal effectiveness.

On the other hand, fourteen competency findings from prior research do not appear to have a direct relationship to the findings in this study. As indicated earlier, this may be attributed to highly specialized competency areas (and not appropriate for multidisciplinary practice). However, a closer look is warranted.

It is important for the reader to keep in mind that the preceding list is not intended to prioritize competency areas in terms of value, relevance or need. Rather, it

is simply a summary of the contribution of this dissertation to prior research reviewed in Chapter Two. Obviously, additional research is indicated, which I will expand on later in this chapter. I am hopeful, however, that the matrix provides a comprehensive summary of the research, thus reducing the fragmented state of our current knowledge I pointed out in Chapter Two. In the next section, I present a multidisciplinary competency model, which can be used to facilitate organizational learning to promote the integration of health and human services.

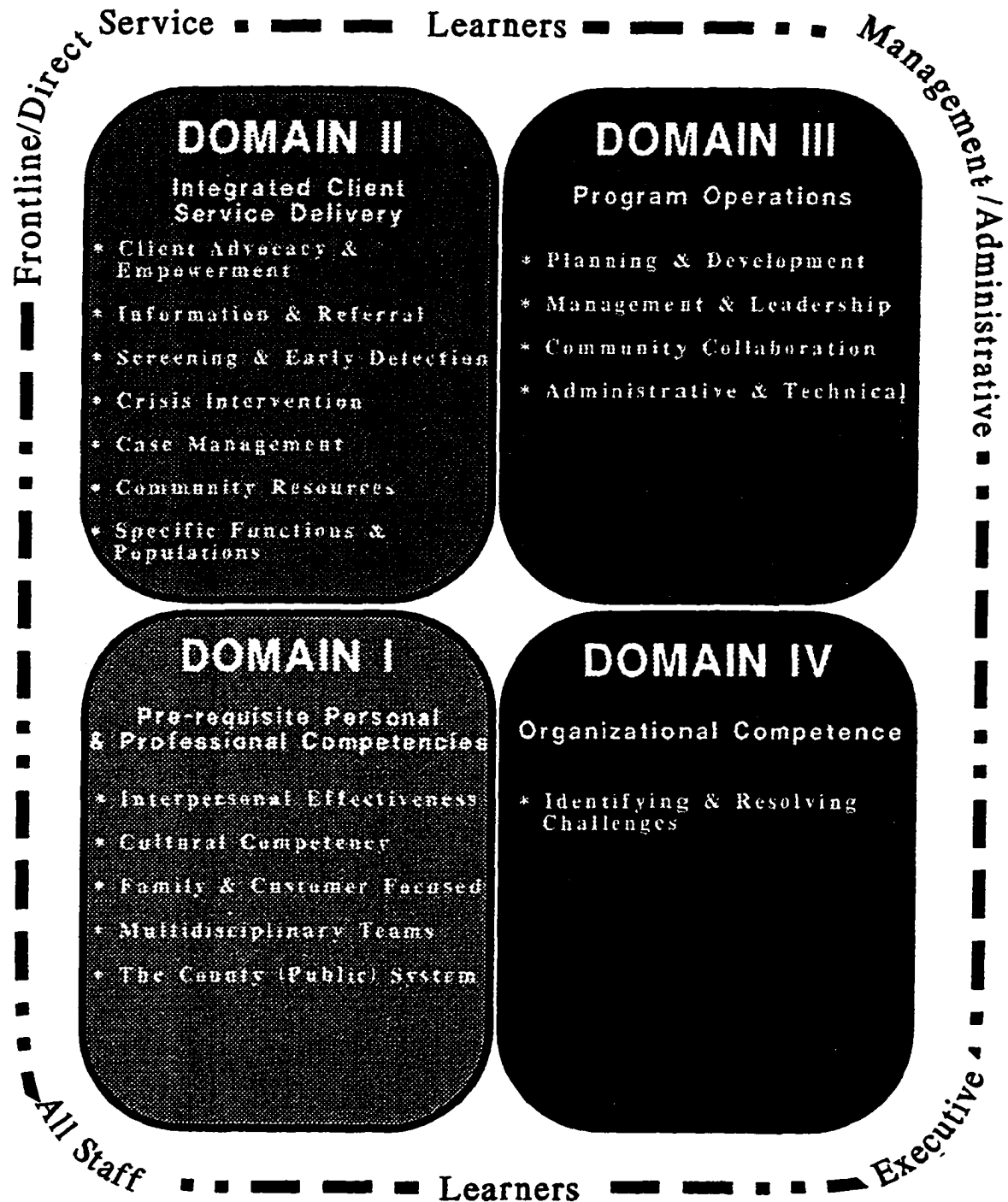
Multidisciplinary Competency Model

A competency model portrays the repertoire of skills and requisite abilities and personal qualities as they relate to the specific demands of a certain job (Bard, Bell, Stephen and Webster, 1987). In this section, I introduce a competency model that portrays the four competency domains and related areas (multidisciplinary skills and requisite abilities and personal qualities) needed in an integrated health and human service system. The model is illustrated in Figure 2.

The model includes the four competency domains and seventeen related competency areas. In addition, the model is dynamic in several respects.

First, the model reflects the wide range of competencies needed by a multidisciplinary team providing integrated health and human services in a public system. For example, many members of the PEIT needed to acquire competencies in all four domains. In more traditional service settings, Domain III competencies, for

Figure 2. A Multidisciplinary Competency Model for an Integrated Health and Human Services System



example, were linked exclusively to persons in managerial/administrative positions. In addition, Domain IV competencies were linked exclusively to persons in executive and top management ranks. I feel the data provided by the PEIT illustrates a more collaborative, integrative picture. Since members of the team participate in program operations and organizational competence, they therefore need to acquire competence in those areas. It is important to consider an individual's interest and accountability when assessing learning needs and designing development interventions.

Second, the four domain panels are not discrete—they are interdependent. A learning need in Domain I may be highly related to a learning need in Domain II, depending on the learner and the organizational context. If you recall from Chapter Four, many PEIT quotes revealed learning needs that ran across competency areas and competency domains.

Third, the dotted line encompassing the four panels illustrates movement and represents the diversity of learners in a health and human services system. In the San Diego County Health and Human Services Agency, for example, there are three primary job groupings: Frontline/Direct Service, Management/Administrative Support, and Executive. Members of the PEIT represented all three groups. Domain I competencies are predominantly relevant for all employees, regardless of classification. Domain II competencies are predominantly relevant for frontline/direct service staff, regardless of discipline or specialty. Domain III competencies are predominantly

relevant for employees in supervisory, managerial or administrative (including clerical support) classifications. Domain IV competencies are predominantly relevant for executive level staff and policy makers.

“Predominantly relevant” means that the majority of learners in a given job grouping will probably need to acquire and maintain competence in the predominant domain. However, the dotted line illustrates movement for learners. For example, a direct service employee may need to acquire competence in program operations, particularly if a collaborative management or leadership model is implemented in their program/facility. This was evident with the PEIT. In addition, an executive may need to acquire competence in integrated client service delivery areas in order to best identify and resolve challenges. In short, learners and learning priorities need to be matched in response to the needs of clients and families served by the team, program and system and linked to persons who are both interested in and held accountable for specific responsibilities and functions.

This competency model can be used to facilitate learning at an individual, team and/or organizational level to facilitate the integration of health and human services. For example, the model can be used to prioritize competencies required in a given program or context. Individuals and teams could be assessed against these competencies. Learning needs can then be identified, and responsive training and development programs could be designed. The model could also be used to map out

organization-wide assessments and the design of remedial interventions. Additional research is indicated to explore the potential of this model in organizational settings, which is the focus of the next section.

Limitations

This descriptive study was limited in two interrelated ways. First, the fact that the PEIT was a pilot project must be considered and, second, that this study is based primarily on the perceptions of research participants.

The Hawthorne effect provides insight into the “pilot” phenomenon. Simply put, the Hawthorne effect is a change in behavior that occurs when individuals know they are being observed (Johnson & Johnson, 1997; Roethlisberger & Dickson, 1939; Mayo, 1933). In her pioneering work on innovation in organizations, Kanter (1983) noted that “... being singled out to be in a highly visible experiment was highly motivating in and of itself” (p. 409). The PEIT began as a highly visible innovation and, therefore, probably influenced participant responses. In addition, these influences can lead to the formation of group norms. And, as Gabor (1990) noted, group norms have a powerful effect on overall worker output. For example, during the assessment and decision making process in professional groups, Parlett (1991) argued:

... assessments are rarely carried out in isolation. Instead, there is a collaborative review process in which opinions are exchanged, reports combined, and a composite picture painted. A likely potent influence on

decisions is the power of group consensus and the suppression of individual differences. (p. 227).

The Hawthorne effect needs to be considered given the innovative, pilot status of the PEIT. The data collected from interviews and focus group in this dissertation may reflect this influence.

Human perception is another phenomenon that must be considered. There are three major factors that influence perception and, hence, have influenced the data in this study. First, physiological influences impact perception, such as vision, hearing, taste, odor, temperature, gender, health, fatigue, height, hunger and daily cycles (Adler & Rodman, 1982). In terms of the PEIT, one can consider the temperature and time of day in the settings where data was collected. Second, social roles influence perception. One factor that determines roles and impacts perception is sex (Eakins & Eakins, 1978). Given that all members of the PEIT were female is a significant consideration here.

Occupational roles is another variable that can impact perception. The kind of work we do often governs our view of the world (Zimbardo, Haney & Banks, 1973). As I noted in Chapter Four, PEIT members expressed professional differences, tied to their perceived occupational role, regarding the notion of accepting gifts from clients. Another implication of occupational roles is that they may lead to “occupational correctness”, in that team members are constrained by the paradigms and practices of

their respective discipline. This can lead to what Joel Barker (1990) refers to as “paradigm paralysis”, whereby persons are unable or unwilling to perceive beyond their current lenses. This situation prevents persons from coming to know what they don’t know, and hence what they need to learn. In addition, my role as an employee of the same system in which the PEIT functions is another occupational element that may have impacted informant perception and responses and researcher interpretation.

The term “competency” is challenged by a thoughtful examination of occupational role perception. I feel it reflects the expert-oriented learning model and, arguably, evokes negative images of dominance, oppression, arrogance, and hierarchy. It would appear that another, more egalitarian term is needed—one that is more learner-oriented.

Finally, consumer perception has not been addressed in this study. Given the unique needs of public consumers in the context of health and welfare reform noted in Chapters One and Two, it is important to consider the roles played by consumers and families of public services and how these roles impact perception and their implications for practitioner development and success.

In addition to physiology and social roles, cultural factors also influence perception (Prosser, 1978). If you recall, two members of the PEIT are Hispanic, bilingual Spanish. The other five members are Caucasian, monolingual English. The impact of these cultural variables are another consideration.

In short, this study was limited by virtue of its pilot status and the perceptual variables inherent in human nature. Additional research and development is needed to build on the competencies that were constructed in this study. Next, I listed recommendations for future research and development.

Suggestions for Future Research and Development

Given the preceding limitations, additional research and development is needed to critique and validate the initial set of competencies identified in this study.

I recommend additional qualitative and quantitative studies in both public and private settings. For example, a Delphi study among multidisciplinary experts and practitioners, a case study / comparison of several multidisciplinary teams, focus groups among consumers and families of public services, and/or a survey consisting of the seventeen competencies could be conducted to validate and prioritize the relevance and scope of the competencies identified in this dissertation. Some questions that could be addressed include: 1) What are the variables that produce high correlation among the competency areas identified in this dissertation with prior research? 2) Are these competencies relevant in private as well as public settings? 3) Are these competencies relevant in other county/public systems? 4) How does "pilot" status impact practitioner perception of essential competencies? 5) To what extent do social roles (sex, occupational and cultural) impact perception of competencies? 6) What are consumer/family perceptions of competencies and how do they compare with

practitioner perceptions? 7) What is a more learner-oriented term for “competency”? 8) What are the implications of these competencies for collaborative management and leadership? 9) What are the implications of these competencies in pre-service, academic settings? 10) How, if at all, can identification of multidisciplinary competencies inform policy-making?

Innovative development work is also indicated. As I stated earlier in this chapter, these multidisciplinary competencies can serve as a basis for policy development, curriculum design and development, performance appraisal, reward and recognition system design, and organizational assessment/intervention/development programs. Applications such as these will yield valuable field data.

These recommendations will yield additional data useful in both academic and professional contexts. I am hopeful others pursue these paths to support multidisciplinary efforts to facilitate the integration of health and human services.

Conclusion

In this dissertation, I argued the need for a descriptive study to identify the core multidisciplinary competencies needed in an integrated public health and human service system. Through an analysis of interviews and a follow-up focus group, four competency domains (and seventeen related competency areas) emerged. I framed the data into competency statements, illustrated the contribution of this study to prior research, presented a multidisciplinary competency model to facilitate organizational

learning for integrating health and human services, discussed the limitations of this study and offered suggestions for future research and development.

I found the experience to be very enlightening. In retrospect, I was amazed at how much data was produced by a small data source (six interviews; one follow-up focus group). Qualitative research methodology proved valuable in that a wide spectrum of competency domains and areas emerged. I am very grateful to the PEIT for allowing me to serve as the conduit for their unique and valuable experience. Their rich perceptions certainly add validity to the learner oriented competency model. My hope is that this dissertation can serve as a testament to their pioneer resourcefulness, enthusiasm, dedication and innovation.

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APPENDIX A - INFORMED CONSENT FORM

This form shall serve as the written agreement to protect the rights of participants of the Prevention, Early Intervention Team (PEIT) in Brian Moffitt's doctoral research project.

1. The purpose of the study is to identify the core multidisciplinary competencies perceived to be essential in an integrated health and human services system. My participation will help the researcher identify these competencies and subsequently develop continuing education programs that I and other San Diego County Health and Human Services Agency staff may participate in and benefit from.
2. The procedure for the research will be qualitative; participation will involve:
 - A. Attendance at and participation in one tape recorded, forty five to sixty minute interview which will be held at a location of my choice. This interview will be transcribed verbatim.
 - B. Attendance at a ninety minute focus group with fellow PEIT members (non tape recorded) at a location of the choice of the PEIT.
 - C. I will have an opportunity to review the transcript of my interview and add, delete or correct any portion.
 - D. If necessary, I may be contacted by the researcher for a follow up interview by phone to ensure clarity and accuracy.
3. No risks other than those encountered in daily life are anticipated.
4. The PEIT will be identified in the study as the data source. All individual responses will be confidential. My name, job title or discipline will not be referenced in the quotes or descriptions. Tapes and transcripts will be kept in a locked file during the study, then destroyed upon completion of the research.
5. I will have an opportunity to ask questions and seek clarification before agreeing to participate in the research. The study is voluntary; non participation or withdrawal from the study will in no way affect my job status. If I participate, I may contact the researcher with any questions or concerns during or after the data collection period.
6. There is no agreement, written or verbal, beyond that expressed on this consent form.

I, the undersigned, understand the above explanation and, on that basis, consent to my voluntary participation in this research.

Signature of Participant

Date

Signature of the Researcher

Date

Signature of a Witness

Date

Done at

City

State

APPENDIX B - INTERVIEW GUIDE

1. Can you describe a typical day in your job as a member of the PEIT?
2. Can you describe the knowledge, skills and attitudes you needed to do your job?
3. Can you think of a work situation as a member of the PEIT that you found particularly rewarding and successful? In your opinion, what was the key to success in this situation?
4. Can you describe a situation where you didn't feel you had enough training to do your job effectively? If so, what kind of training would have helped you in this situation?
5. What kinds of expertise from other members of the PEIT have you found helpful in your work?
6. What kinds of expertise do you possess that other members of the PEIT have found helpful?
7. What do you think direct service practitioners need to learn to be able to effectively work in the newly integrated Health and Human Services Agency?
8. What factors helped or supported you in your work?
9. What factors hindered or limited the effective functioning of the PEIT?
10. Is there anything else you would like to add?